

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445445                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>09/04/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Celina Health and Rehabilitation Center                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>120 Pitcock Lane<br>Celina, TN 38551 |                                                 |
| 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 0584<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, observation, and interview, the facility failed to provide a clean and sanitary environment to ensure cleanliness of a stand-up personal fan for 1 resident (Resident #8) of 61 residents reviewed for a clean and sanitary environment. The findings include: Review of the facility's policy titled, Cleaning and Disinfecting Residents' Rooms, revised 8/2013, revealed .environmental services will be disinfected (or cleaned) on a regular basis .and when surfaces are visibly soiled . Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Diabetes, History of a Stroke with Hemiplegia, Pulmonary Edema, and Dysphagia. During observations on 9/2/2025 at 10:55 AM and on 9/3/2025 at 2:30 PM, Resident #8's room revealed a portable stand-up fan by the wall facing toward the bed. The fan blades had a large amount of gray dust and thick debris resembling clumped gray fibers which had accumulated on the protective grille. During an observation and interview on 9/4/2025 at 10:34 AM, the Housekeeping Director confirmed Resident #8's stand-up fan had a large amount of gray dust and thick debris resembling clumped gray fibers which had accumulated on the protective grille, which should not be present with routine cleaning.</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  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                   |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>445445                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                          | (X3) DATE SURVEY<br>COMPLETED<br><br>09/04/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Celina Health and Rehabilitation Center                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>120 Pitcock Lane<br>Celina, TN 38551 |                                                 |
| 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 0698<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, medical record review, and interview, the facility failed to complete dialysis communication forms consistently for 1 resident (Resident #37) of 2 residents reviewed for dialysis. The findings include: Review of the facility's policy titled, End-Stage Renal Disease, Care of a Resident with, dated September 2010, revealed .Agreements between the facility and the contracted ESRD (end stage renal disease) facility include all aspects of how the resident's care will be managed, including .How information will be exchanged between the facilities . Medical record review revealed Resident #37 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease, Chronic Obstructive Pulmonary Disease, and Metabolic Encephalopathy. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #37 received dialysis services. Review of a comprehensive care plan for Resident #37 revised on 9/3/2025, revealed .I require hemodialysis due to end stage renal failure .I receive hemodialysis three times a week on Monday, Wednesday, and Friday . During a medical record review and interview on 9/4/2025 at 11:15 AM, the Assistant Director of Nursing (ADON) stated there was no documentation of dialysis communication sheets for 4 dialysis visits 8/15/2025, 8/18/2025, 8/20/2025, and 8/22/2025 for Resident #37. During an interview on 9/4/2025 at 11:20 AM, the Director of Nursing (DON) stated it was the facility's expectation to send dialysis communication sheets with residents to dialysis services for each dialysis treatment. The DON confirmed dialysis communication sheets for Resident #37 were not completed. |                                                                                   |                                                 |