STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER: White House Health Care Inc		STREET ADDRESS, CITY, STATE, ZIP CODE: 2871 Highway 31w White House, TN 37188	

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, record review, and interview, the facility failed to provide information to the residents regarding their right to refuse medical or surgical treatment or to formulate an advance directive for 3 of 24 (Resident #6, #17, and #36) residents reviewed for advance directives. The findings include: 1. Review of the facility ' s policy Resident' s Rights Regarding Treatment and Advance Directives dated 7/26/2024, revealed It is the policy of this facility to support and facilitate a resident ' s right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. Advance directive is a written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law relating to the provision of health care when the individual is incapacitated On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive 2. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Dementia, Cerebral infarction, and Traumatic Brain Injury. Review of the LETTERS OF CONSERVATORSHIP dated 4/18/2011, revealed no documentation of instructions for advance directives. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #6 was severely cognitively impaired. There was no documentation in the medical record if Resident #6 had an Advance Directive or if the Resident would like to formulate an Advance Directive. 3. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Hypertension, Chronic Kidney Disease, and Chronic Obstructive Pulmonary Disease. Review of a quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 which indicated Resident #17 was severely cognitively impaired. (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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	445513	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White House Health Care Inc	2871 Highway 31w White House, TN 37188

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation in the medical record if Resident #17 had an Advance Directive or if the Resident would like to formulate an Advance Directive. 4. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE], with diagnoses including Quadriplegia, Hypertension, and Chronic Kidney Disease. Review of the quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 which indicated Resident #36 was cognitively intact. There was no documentation in the medical record if Resident #36 had an Advance Directive or if the Resident would like to formulate an Advance Directive. 5. During an interview on 9/10/2024 at 1:54 PM, the Administrator confirmed that she was unable to provide any further documentation regarding advance directives. 49311

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on facility policy, medical record review, and interview, the facility failed to conduct quarterly care conference meetings for 4 of 21 sampled residents (Resident #18, #33, #36, and #54) reviewed. The findings include: 1. Review of the facility's undated policy titled, Care Plans, Comprehensive Person-Centered revealed The IDT [Interdisciplinary Team] includes .the resident and the resident's legal representative .Each resident ' s comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation .including the right to .participate in the planning process .See the care plan and sign it .resident will be informed of his or her right to participate in his or her treatment .The Interdisciplinary Team must review and update the care plan .At least quarterly, in conjunction with the required quarterly MDS assessment .The resident has the right to refuse to participate in the development of his/her care plan and medical nursing treatments. Such refusals will be documented in the resident ' s clinical record . 2. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including Multiple Sclerosis, Dementia, and Anxiety. Review of the Care Conference Report for Resident #18 revealed the last Care Conference was conducted on 12/22/2023. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a BIMS score of 13, which indicated Resident #18 was cognitively intact. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated Resident #18 was cognitively intact. Review of the quarterly MDS assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #18 was cognitively intact. The facility was unable to provide documentation that a quarterly Care Conference was conducted with the Resident or Responsible Party (RP). 3. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE], with diagnoses including Multiple Sclerosis, Chronic Obstructive Pulmonary Disease and Depression. Review of the Care Conference Report for Resident #33 revealed last Care Conference was conducted on 1/23/2024. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #33 was cognitively intact. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #33 was cognitively intact. The facility was unable to provide documentation that quarterly Care Conferences were conducted with the Resident or RP. 4. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE], with diagnoses including Quadriplegia, Polyneuropathy, Neuromuscular Dysfunction of Bladder and Chronic Kidney Disease. Review of the Care Conference Report for Resident #36 revealed last Care Conference was conducted on 2/2/2024. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #36 was conatively intact. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #36 was conatively intact. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #36 was conatively intact. The facility was unable to provide documentation that quarterly Care Conferences were conducted with the Resident or RP. 5. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Hemiplegia, Dysphagia, and Vascular Dementia. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 4, which indicated resident #54 had severe cognitive impairment, was dependent on staff for all care, and was on a mechanical diet. Resident was coded for oxygen and was not receiving any therapy. The facility was unable to provide documentation of quarterly Care Conferences with the Resident ' s RP. 6. During an interview on 9/11/2024 at 4:09 PM the Director of Nursing (DON) stated she was unable to provide quarterly care plan meetings documentation and stated, that is something that we will have to work on .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47835 Based on policy review, observation, and interview, the facility failed to ensure food was stored properly when unlabeled and undated items were found in 2 of 3 (Dogwood Hall and Central) nourishment refrigerators observed. The findings include: 1. The facility's undated policy titled, FOODS BROUGHT IN FROM OUTSIDE SOURCES revealed .When food(s) is brought in from outside sources for the residents .require refrigeration .food items should be labeled with .resident ' s name .date the item(s) was purchased or prepared .and the name of the item . The facility ' s undated policy titled, Refrigerator Food Storage Policy Summary .Labeling & Dating . revealed .Before putting anything in the refrigerator, please ensure the food is in a tightly sealed container and there is a label and date on the product with the resident ' s name and current date . 2. Observation in the Dogwood Hall Nutrition Refrigerator on 9/11/2024 at 12:15 PM and 3:15 PM, revealed an open unlabeled and undated bag of radishes. 3. Observation in the Central Nutrition Refrigerator on 9/11/2024 at 12:21 PM and 3:19 PM, revealed a bag containing undated food. 4. During an interview on 09/11/24 03:22 PM, the Registered Dietician confirmed all items in the nutritional refrigerators should be labeled and dated.