STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445513	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
White House Health Care Inc	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to provide an environment free of hazardous materials for 6 of 74 (Resident #5, #9, #30, #65, #75, and #78) sampled residents reviewed for accident hazards. The findings include: 1. Review of the facility policy titled, Environmental Safety Policy, dated 1/31/2025, revealed .The purpose of this policy is to provide a safe, clean, and hazard-free environment for residents, staff, visitors, and contractors within the long-term care (LTC) facility.Hazardous Materials Management All chemicals stored in labeled, locked, and ventilated areas.^^ 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Epilepsy, Diabetes, and Vascular Dementia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #5 was cognitively intact. Observation in Resident #5's room on 11/16/2025 at 1:55 PM and 3:05 PM, revealed 2 orange disposable razors in an opened bag on top of a small table in the resident's room. During an observation and interview in Resident #5's room on 11/16/2025 at 3:08 PM, Licensed Practical Nurse (LPN) B was asked if disposable razors should be left out unsecured and unattended in a resident's room. LPN B stated, No, they should not. 3. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Dementia, Diabetes, and Bipolar Disorder.^ Review of the^annual MDS assessment dated [DATE], revealed Resident #9 scored a 6 on the BIMS assessment, which indicated Resident #9 was severely cognitively impaired. Observation in Resident #9's shared bathroom on 11/16/2025 at 1:16 PM, revealed 2 blue disposable razors on the bathroom sink. During an observation and interview in Resident #9's shared bathroom on 11/16/2025 at 3:10 PM, revealed 2 blue disposable razors remained on the resident's bathroom sink. LPN B was asked if razors should be left out unattended and unsecured in a resident's bathroom. LPN B stated, No, they should not. 4. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Dementia, Depressive Disorder, and Chronic Obstructive Pulmonary Disease. Review of the quarterly MDS assessment dated [DATE], revealed Resident #30 scored a 3 on the BIMS assessment, which indicated Resident #30 was severely cognitively impaired. Observation in Resident #30's bathroom on 11/16/2025 at 2:07 PM and 2:59 PM, revealed 1 pink disposable razor and 1 blue and green disposable razor in a cup on the bathroom counter and 1 blue and green disposable razor in a small dish on the bathroom counter. During an observation and interview in Resident #30's bathroom on 11/16/2025 at 3:01 PM, LPN C was asked if disposable razors should be left out unsecured and unattended in a resident's room or bathroom. LPN C stated, No. 5. Review of the medical record revealed Resident #65 was admitted to the facility on [DATE], with diagnoses including Right Femur Fracture, Anxiety, and Depressive Disorder. Review of the admission MDS assessment dated [DATE], revealed Resident #65 scored an 11 on the BIMS assessment, which indicated Resident #65 was moderately cognitively impaired. Observation in Resident #65's shared bathroom on^11/16/2025 at 2:03 PM, revealed a bottle of (Named) cool mint mouthwash on the (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's bathroom counter. During an observation and interview in Resident #65's shared bathroom on 11/16/2025 at 4:33 PM, revealed the bottle of (Named) cool mint mouthwash remained on the bathroom counter. LPN C was asked how should the (Named) mouthwash be stored. LPN C stated, It should be locked up in the cart. 6. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dementia, Heart Failure, and Unsteadiness on Feet. Review of the quarterly MDS assessment dated [DATE], revealed Resident #75 scored an 8 on the BIMS assessment, which indicated Resident #75 was moderately cognitively impaired. Observation in Resident #75's bathroom on 11/16/2025 at 1:23 PM and 4:57 PM, revealed an orange can of aerosol disinfectant spray on the bathroom counter. During an observation and interview in Resident #75's bathroom on 11/16/2025 at 5:05 PM, LPN B was asked if the aerosol disinfectant spray should be left out in the resident's bathroom unsecured and unattended. LPN B stated, No it should not be left out. 7. Review of the medical record revealed Resident #78 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, Osteoarthritis, Neuropathy, and Atrial Fibrillation. Review of the annual MDS assessment dated [DATE], revealed Resident #78 scored a 14 on the BIMS assessment, which indicated Resident #78 was cognitively intact. Observation in Resident #78's bathroom on 11/16/2025 at 2:01 PM and 4:42 PM, revealed a can of (Named) aerosol air sanitizer spray on the bathroom counter, a bottle of (Named) stain remover spray, and a container of lemon scented disinfecting wipes on top of a 3-drawer cabinet. During an observation and interview in Resident #78's bathroom on 11/16/2025 at 5:10 PM, LPN B was asked if the aerosol air sanitizer spray, stain remover spray, and disinfecting wipes should be left out unsecured and unattended in the resident's bathroom. LPN B stated, No, they shouldn't.^ During an interview on 11/18/2025 at 3:35 PM, the Director of Nursing (DON) was asked if disposable razors should be left out unsecured and unattended in resident rooms or bathrooms. The DON stated, .no. The DON was asked if razors should be stored and secured out of reach. The DON stated, Yes. The DON was asked if disinfectant spray, disinfecting wipes, and mouth wash, should be left out unsecured and unattended in resident rooms or bathrooms. The DON stated, It should be stored out of reach.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to store medications in accordance with facility policy when medications were found unsecured and unattended in resident's rooms and bathrooms for 3 of 74 (Resident #45, #75, and #87) residents. The findings include: 1. Review of the facility policy titled, Storage of Medications, with a revised dated of 4/2019, revealed .The facility stores all drugs and biologicals in a safe, secure, and orderly manner .nursing staff is responsible for maintaining medication storage . 2. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE], with diagnoses including Supraventricular Tachycardia and Sepsis. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #45 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #45 was moderately cognitively impaired. Review of the Physician's Order dated 11/26/2024, revealed Cleanse sacral area with NS [normal saline], apply [Named Menthol and Zinc Oxide cream] [a cream used to protect and heal skin irritation] q [every] shift to affected area and as needed.every shift. Observation in Resident #45's shared bathroom on 11/16/2025 at 1:14 PM and 4:55 PM, revealed a tube of (Named Menthol and Zinc Oxide cream) on the back of the toilet. During an observation and interview in Resident #45's bathroom on 11/16/2025 at 5:01 PM, Licensed Practical Nurse (LPN) B was asked if the tube of (Named Menthol and Zinc Oxide cream) should be left unsecured in the resident's bathroom on the back of the toilet. LPN B stated, No it should not. 3. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dementia, Heart Failure, and Unsteadiness on Feet. Review of the quarterly MDS dated [DATE], revealed Resident #75 scored an 8 on the BIMS assessment, which indicated Resident #75 was moderately cognitively impaired. Review of the Physician's Orders dated November 2025, revealed no order for antifungal powder spray. Observation in Resident #75's bathroom on 11/16/2025 at 1:23 PM and 4:57 PM, revealed an aerosol can of antifungal powder spray on the back of the toilet. During an observation and interview in Resident #75's bathroom on 11/16/2025 at 5:05 PM, LPN B was asked if aerosol antifungal powder spray should be left out unsecured and unattended on the back of a resident's toilet. LPN B stated, No it should not be left out. 4. Review of the medical record revealed Resident #87 was admitted to the facility on [DATE], with diagnoses including Chronic Pulmonary Disease, Emphysema, Pneumonia, Acute Respiratory Failure, Muscle Weakness, and required assistance with personal care. The admission MDS assessment for Resident #87 was in the completion process at the time of the survey. Observation in Resident #87's room on 11/16/2025 at 5:06 PM and 11/17/2025 at 7:37 AM, revealed an Albuterol Sulfate Inhalation Aerosol inhaler (used to treat breathing difficulty) on Resident #87's nightstand. During an observation and interview in Resident #87's room on 11/16/2025 at 5:09 PM, LPN D verified the medication left on top of Resident #87's nightstand was an albuterol inhaler. LPN D asked Resident #87 when he got the albuterol inhaler. Resident #87 stated .she [wife] brought it in today and I have another in the drawer that I took one puff of .I will take it [albuterol inhaler] when I need it . LPN D confirmed the medication in the resident's drawer was Trelegy Ellipta, a powder inhaler used to treat breathing difficulty. LPN D verified the medications were opened and the dosage indicators revealed usage of the medications. LPN D was asked where residents' medications should be stored. LPN D stated, In the med cart . Review of a progress note dated 11/16/2025 at 10:22 PM, revealed Resident has orders to keep Albuterol Nebulizer at bed side. Review of the Physician's Telephone Order dated 11/16/2025, revealed an order for Trelegy Ellipta and to self-administer 2 puffs of the albuterol inhaler every 6 hours as needed. The resident may keep at bedside and self-medicate. The untimed telephone order had a Physician's signature, dated 11/16/2025. Review of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Physician's Telephone Order dated 11/16/2025, revealed May self-administer albuterol inhaler at his preference. The untimed telephone order had a Physician's signature, dated 11/19/2025. The telephone order to self-administer medication was written after the observation on 11/16/2025. The facility failed to provide an evaluation for self-administration of medication for Resident #87. During an observation and interview in Resident #87's room on 11/17/2025 at 7:37 AM, LPN E confirmed the albuterol inhaler was on the resident's nightstand. LPN E was asked how medication should be stored. LPN E stated, .it should be in the med drawer unless he can self-administer .I did not get report that he had the medication . LPN E was asked if the resident does have an order to self-administer where should the medication be stored. LPN E stated, At the bedside in the drawer . During an interview on 11/18/2025 at 3:35 PM, the Director of Nursing (DON) was asked if antifungal powder spray or prescription creams/ointments should be left in the resident's rooms or bathrooms unsecured and unattended. The DON stated, It should be stored out of reach. During an interview on 11/18/2025 at 3:43 PM, the DON was asked how medications should be stored. The DON stated, They should be stored in a med cart .some residents request to be stored at bedside. The DON was asked to explain to be stored at bedside. The DON stated, An alert and oriented resident may request meds at bedside for treatment .the nurse will complete a self-administration record and place in the chart. The DON was asked if the resident can self-administer how should the med be stored. The DON stated, The medication should be stored in the residents' room in personal belongings. The DON was asked to explain personal belongings. The DON stated, In there beside drawer . The DON was asked should residents have medications stored on top of their nightstand. The DON stated, Typically, not on top of the nightstand.