STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445520	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Blount County	1965 Stewart Lane Louisville, TN 37777

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation and interviews the facility failed to provide dignity for 1 resident (Resident #90) of 24 residents reviewed for dignity.The findings include:Review of the facility policy titled Activities of Daily Living (ADLs), dated 9/10/2024, revealed .For residents who are unable to carry out activities of daily living receives the necessary services to maintain .grooming .Review of the medical record revealed Resident #90 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Diabetes, and Dementia.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #90 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment and required partial/moderate assistance with personal hygiene.Review of a comprehensive care plan for Resident #90 dated 6/5/2026, revealed .ADL assistance .assist with .ADL's as needed .During an observation/interview on 6/29/2026 at 12:01 PM in Resident #90's room, revealed resident lying in bed with a large amount of facial hair on her upper lip. Resident #90 expressed interest in having the facial hair removed. Review of the facility's bathing schedule revealed Resident #90 was scheduled to receive showers on Wednesday, Saturday and as needed (PRN). Further review revealed Resident #90 received a bed bath on 6/27/2026.During an interview on 6/29/2026 at 11:30 AM, Certified Nurse Assistant (CNA) A stated Resident #90 required assistance with shaving and Resident #90's shower was on Wednesday and Saturday. CNA further stated shaving was to be offered on shower days. During an interview/observation on 6/29/2026 at 11:45 AM, Licensed Practical Nurse (LPN) A stated Resident #90 was to receive showers on Wednesday and Saturday. LPN A stated residents were to have facial hair removed on shower days. LPN A confirmed Resident #90 had a large amount of facial hair and had not been shaved. During an observation and interview on 6/29/2026 at 12:05 PM, in Resident #90's room, the Director of Nursing (DON) stated staff were to offer shaving for male and female residents on shower days and as needed. The DON confirmed Resident #90 had a large amount of facial hair and had not been shaved.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **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 honor the bathing preferences of 2 residents (Resident #73 and #106) of 24 residents reviewed. The findings include: Review of the facility policy titled, Activities of Daily Living (ADLs), dated 9/10/2024, revealed .the resident will receive assistance as needed to complete activities of daily living (ADL's) .Any change .will be reported to the nurse . Review of the facility policy titled, Resident Rights, dated 9/26/2025, revealed .resident has the right to receive the services .included in care plan .make choices about aspects of his or her life in the facility that are significant to the resident . Review of the medical record revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including Fracture of Left Femur, Diabetes, and Muscle Weakness. Review of a comprehensive care plan dated 6/15/2026, revealed Resident #73 had an .ADL [Activities of Daily Living] assistance .to maintain or attain highest level of function .assist with .adl's as needed . Continued review revealed the care plan did not reflect the resident's bathing preference. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #73 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #73 required substantial/maximal assistance with shower. Review of the Kardex (Certified Nurse Assistant (CNA) Care Plan) for Resident #73 revealed, .Bathing .ADL-Bathing-SHOWER-Tuesday and Friday Evening and PRN [as needed]. Review of the facility documentation for Resident #73 titled .ADL-Bathing-SHOWER-Tuesday and Friday evening AND PRN . dated from 6/16/2026 to 7/1/2026 revealed no showers were given. Further review revealed Resident #73 received a bad bath on 6/19/2026. Review of the medical record for Resident #73 revealed no documentation of refusal of showers for Resident #73. During an interview on 6/29/2026 at 12:43 PM, Resident #73 stated he had not received a shower since admission to the facility. Resident #73 further stated he had received bed baths, but his preference was to receive a shower. During an interview on 7/1/2026 at 2:15 PM, Resident #73 stated he still had not received showers since admission but was hoping for one today [7/1/2026]. Review of the medical record revealed Resident #106 was admitted to the facility on [DATE] with diagnoses including Dementia, Anxiety, Muscle Weakness, and Depression. Review of a quarterly MDS assessment dated [DATE], revealed Resident #106 scored a 4 on the BIMS assessment which indicated the resident had severe cognitive impairment and was dependent on staff for showers. Review of a comprehensive care plan dated 4/30/2026, revealed Resident #106 had a .ADL assistance .to maintain or attain highest level of function .assist with mobility and ADLs as needed . Continued review revealed the care plan did not reflect the resident's bathing preference. During an interview on 6/29/2026 at 10:26 AM, in Resident #106's room the Responsible Party stated Resident #106 had not had a shower in over 30 days. The Responsible Party further stated Resident #106 had received bed baths but Resident #106 and the Responsible Party preferred showers. Review of the Kardex for Resident #106 revealed, .Bathing .ADL-Bathing-SHOWER-Wednesday, Saturday and PRN. Review of the facility documentation for Resident #106 titled ADL-Bathing-SHOWER-Wednesday, Saturday, and PRN, dated from 5/27/2026 to 6/27/2026 revealed bed baths were given. Further review revealed Resident #106 received bed baths on 5/30/2026, 6/3/2026, 6/10/2026, 6/13/2026, 6/20/2026, and 6/27/2026. Continued review revealed no showers were provided to Resident #106 per the resident's preference. Review of the medical record for Resident #73 revealed no documentation of refusal of showers for Resident #106. During an interview on 6/29/2026 at 2:00 PM, CNA B stated showers were done twice a week and if the resident refused, the nurse would be informed, and the refusal would be documented. Bed baths were only to be offered if shower were refused. CNA B further stated she would refer to the Kardex for shower days. During an interview on 6/29/2026 at 2:06 PM, the Unit Manager (UM) stated all (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents were to be offered a shower and if they refused, the nurse was to be informed and then a bed bath offered. UM further stated it was Resident #106's preference to receive a shower and not a bed bath. The UM manager was unaware of Resident #106 refusing showers. UM confirmed Resident #106 had received bed baths and had not received the showers per the resident preference. During an interview on 6/29/2026 at 8:30 PM, CNA C stated residents received showers twice a week. CNA C further stated residents were to be offered showers first and then a bed bath if refused. CNA C stated if a resident refused a shower she was to report the refusal to the nurse, and any refusals of showers were to be documented in the medical record. During an interview on 7/1/2026 at 10:25 AM, the Director of Nursing (DON) stated residents were to receive a shower twice a week and as needed. The DON further stated showers were to be offered first and if refused the CNA was to report the refusal to the nurse and the refusal documented in the medical record. The DON confirmed Residents #73 and #106 did not have a care plan related to refusal of showers or a preference for bed baths. The DON confirmed Residents #73 and #106 had received bed baths instead of the preferred showers.

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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, observations, and interviews, the facility failed to ensure medications were securely stored in 1 medication cart (Medication Cart 1) of 3 medication carts reviewed. The findings include: Review of the facility policy titled, Medication Storage, dated 11/28/22, revealed .the facility must store all drugs and biologicals in locked compartments .permit only authorized personnel to have access . During an observation and interview on 6/30/2026 at 7:52 PM, revealed Licensed Practical Nurse (LPN) B was standing at a medication cart preparing medications. LPN B left the medication cart and entered residents room, leaving the medication cart unlocked and unattended. LPN B returned to the medication cart and confirmed the mediation cart was left unlocked and unattended. LPN B confirmed she should have locked the medication cart when left unattended. During an interview on 6/30/2026 at 8:01 PM, Registered Nurse (RN) A stated there were no wandering residents in the facility. During the night shift observation on 6/30/2026 from 7:42 PM to 8:50 PM, no wandering residents observed throughout facility. During an interview on 7/1/2026 at 10:53 AM, the Director of Nursing (DON) confirmed medication carts should be locked when left unattended.