STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445523	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellpark Health and Rehabilitation	7512 Middlebrook Pike Knoxville, TN 37909

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure a physician order was in place for a non-invasive mechanical CPAP (Continuous Positive Airway Pressure) ventilator for 1 (Resident #66) of 2 residents reviewed for respiratory care. Findings included: A facility policy titled, Physician Orders, reviewed in 01/2026, indicated, It is the policy of this facility to accurately implement orders in addition to medication orders (treatment, procedures) only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. A Face Sheet revealed the facility admitted Resident #66 to the facility on [DATE]. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/21/2025, revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Obstructive sleep apnea was included as an active diagnosis on the resident's MDS. Resident #66's LN [Licensed Nurse]- Daily Skilled, dated 06/20/2025 at 1:41 AM, signed by Licensed Practical Nurse (LPN) #2, revealed documentation that the resident was compliant with CPAP therapy. Resident #66's LN- Daily Skilled, dated 06/21/2025 at 12:59 AM, signed by LPN #2, revealed documentation that the resident was compliant with CPAP therapy. Resident #66's Order Recap [Recapitulation] Report, dated 06/01/2025 through 06/30/2025, did not include an order for the use of a CPAP machine. During an interview on 04/29/2026 at 1:30 PM, LPN #4 stated she completed Resident #66's nursing admission assessment on 06/19/2025. LPN #4 acknowledged she missed the use of the CPAP machine on the assessment and therefore missed obtaining a physician's order for the use of the device. She stated she was unsure how she missed it. During an interview on 04/30/2026 at 9:23 AM, LPN #2 stated she recalled Resident #66 used a CPAP machine at night; however, because she did not admit the resident to the facility, she did not verify the resident had a physician order for the use of the CPAP. During an interview on 05/01/2026 at 12:15 PM, the Nurse Practitioner stated if a resident arrived at the facility with a CPAP device and did not have orders, then a nurse should notify him, and he would order the use of the CPAP machine at the resident's home settings. During an interview on 05/01/2026 at 2:00 PM, the Director of Nursing (DON) reviewed Resident #66's daily skilled notes dated 06/20/2025 and 06/21/2025 and confirmed the notes indicated the resident was compliant with use of a CPAP machine. The DON stated Resident #66 should have had a physician's order for use of the CPAP machine. During an interview on 05/01/2026 at 3:15 PM, the Executive Director stated he deferred his expectation to the DON related to respiratory care and the use of a CPAP machine.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and facility policy review, the facility failed to ensure the correct resident's name was used in a comprehensive care plan for 1 (Resident #59) of 18 residents reviewed for care plans. Findings included: A facility policy titled, Documentation and Charting, dated 01/2026, indicated, It is the policy of this facility to provide, and 5. Assistant in the development of a Plan of Care for each resident. A Face Sheet revealed the facility admitted Resident #59 on 08/06/2025. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/12/2025, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS revealed Resident #59 had an active diagnosis of a hip fracture. Resident #59's Care Plan Report included a focus area, initiated 08/07/2025, that indicated the resident had a potential for alteration in diversional activities related to a preference to initiate activities of choice independently. Interventions directed staff to: invite and encourage group activities for [Name, not Resident #59's name, preferred name, or nickname] (initiated 08/07/2025); [Name, not Resident #59's name, preferred name, or nickname] could propel their wheelchair independently; and encourage [Name, not Resident #59's name, preferred name, or nickname] to go outside for fresh air when the weather was good (initiated 08/07/2025). During an interview on 04/29/2026 at 3:52 PM, the Activities Director (AD) stated she was responsible for initiating activities care plans, and if the activities assistant initiated the care plan, then the AD was responsible for reviewing it. The AD stated she did not know how the name [Name, not Resident #59's name, preferred name, or nickname] became part of Resident #59's care plan. During an interview on 05/01/2026 at 9:55 AM, the Minimum Data Set (MDS) Coordinator stated Resident #59's care plan was not accurate because it used [Name, not Resident #59's name, preferred name, or nickname]. The MDS Coordinator stated that when she reviewed the care plan, if she had noticed [Name, not Resident #59's name, preferred name, or nickname] then she would have changed it. During an interview on 05/01/2026 at 12:33 PM, the Director of Nursing (DON) stated the use of the name [Name, not Resident #59's name, preferred name, or nickname] in Resident #59's care plan was a typo [typographical error] The DON stated that her expectation was that there were never typos. During an interview on 05/01/2026 at 2:33 PM, the Executive Director (ED) stated the name [Name, not Resident #59's name, preferred name, or nickname] was not accurate. The ED stated his expectation was that the correct name, nickname, or preferred name was used throughout a care plan.