

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL536519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2026
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NAME OF PROVIDER OR SUPPLIER CANDLELITE 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 MORTON STREET SHELBYVILLE, TN 37160
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E 001	0720-21 Initial Comments This Rule is not met as evidenced by: An annual licensure and complaint survey for complaint #75246, C #1497, and M #478 was conducted from 2/23/2026 through 3/3/2026, at Candelite 1. Deficiencies were cited with the annual licensure survey under Chapter 0720-21, The Standards for Assisted Care Living Facilities.	E 001		
E 402	0720-21-.04 (2) Administration (2) The licensee must designate in writing a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee. This Rule is not met as evidenced by: Based on review of facility documentation and interview, the facility failed to designate a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee. The findings included: 1. Review of facility documentation revealed the facility did not have a designee in writing as to who would act on administrative matters in the absence of the administrator. 2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator stated she could not come to the facility today and confirmed there was no paperwork at the home in writing of a designee in the absence of the Administrator.	E 402		

Health Facilities Commission
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Angelia D. Nelson-James
STATE FORM

TITLE
Adm. Assistant
(X6) DATE
5/08/26

6899 PY5V11

Health Facilities Commission

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E 001	0720-21 Initial Comments This Rule is not met as evidenced by: An annual licensure and complaint survey for complaint #75246, C #1497, and M #478 was conducted from 2/23/2026 through 3/3/2026, at Canlelite 1. Deficiencies were cited with the annual licensure survey under Chapter 0720-21, The Standards for Assisted Care Living Facilities.	E 001		
E 402	0720-21-.04 (2) Administration (2) The licensee must designate in writing a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee. This Rule is not met as evidenced by: Based on review of facility documentation and interview, the facility failed to designate a capable and responsible person to act on administrative matters and to exercise all the powers and responsibilities of the licensee as set forth in this chapter in the absence of the licensee. The findings included: 1. Review of facility documentation revealed the facility did not have a designee in writing as to who would act on administrative matters in the absence of the administrator. 2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator stated she could not come to the facility today and confirmed there was no paperwork at the home in writing of a designee in the absence of the Administrator.	E 402		

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CANDLELITE 1 **1042 MORTON STREET**
SHELBYVILLE, TN 37160

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E 412	Continued From page 1	E 412		
E 412	<p>0720-21-.04 (5) Administration</p> <p>(5) Infection Control. A Home for the Aged shall have an annual influenza vaccination program which shall include at least:</p> <p>(a) The offer of influenza vaccination to all staff and independent practitioners at no cost to the person or acceptance of documented evidence of vaccination from another vaccine source or facility. The Home for the Aged will encourage all staff and independent practitioners to obtain an influenza vaccination;</p> <p>(b) A signed declination statement on record from all who refuse the influenza vaccination for reasons other than medical contraindications (a sample form is available at https://www.tn.gov/content/dam/tn/health/documents/SampleIndividualFluForm.pdf);</p> <p>(c) Education of all employees about the following:</p> <ol style="list-style-type: none"> 1. Flu vaccination, 2. Non-vaccine control measures, and 3. The diagnosis, transmission, and potential impact of influenza; <p>(d) An annual evaluation of the influenza vaccination program and reasons for non-participation; and</p> <p>(e) A statement that the requirements to complete vaccinations or declination statements shall be suspended by the administrator in the event of a vaccine shortage as declared by the</p>	E 412		

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E 412	<p>Continued From page 2</p> <p>Commissioner or the Commissioner ' s designee.</p> <p>This Rule is not met as evidenced by: Based on review of facility documentation and interview the facility failed to ensure that 2 of 2 (Employee #1 and #2) employees reviewed had the annual influenza vaccination or a signed declination.</p> <p>The findings included:</p> <p>1. Review of facility documentation for Employee #1 revealed no documentation of the annual influenza vaccination or a signed declination.</p> <p>Review of facility documentation for Employee #2 revealed no documentation of the annual influenza vaccination or a signed declination.</p> <p>2. During an interview on 2/24/2026 at 2:41 PM, Employee #1 said she did not know where the paperwork was for the employees.</p>	E 412		
E 415	<p>0720-21-.04 (6)(c) Administration</p> <p>(6) Each home for the aged shall:</p> <p>(c) Maintain documentation of the checks of the "Registry of Persons who have Abused or Intentionally Neglected Elderly or Vulnerable Individuals" prior to hiring any employee.</p> <p>This Rule is not met as evidenced by: Based on facility documentation review and interview, the facility failed to ensure employees were not listed on the abuse registry for 2 of 2 (Employee #1and #2) employees reviewed.</p> <p>The findings included:</p>	E 415		

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E 415	Continued From page 3 1. Review of facility documentation for Employee #1 revealed no documentation was produced for the abuse registry on the employee before she started to work at the facility. Review of facility documentation for Employee #2 revealed no documentation was produced for the abuse registry on the employee before she started to work at the facility. 2. During an interview on 2/24/2026 at 2:41 PM, Employee #1 said she did not know where the paperwork was for the employees.	E 415		
E 417	0720-21-.04 (6)(e) Administration (6) Each home for the aged shall: (e) Post whether they have liability insurance, the identity of their primary insurance carrier, and if self-insured, the corporate entity responsible for payment of any claims. It shall be posted on a sign no smaller than eleven inches (11") in width and seventeen inches (17") in height and displayed at the main public entrance. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to post proof they had liability insurance, the identity of their primary insurance carrier, or if self-insured, the corporate entity responsible for payments of all claims. The findings included: 1. Observations at the front entrance on 2/24/2026 at 9:30 AM, revealed there was no liability insurance posted or paperwork of the	E 417		

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E 417	Continued From page 4 facility having liability insurance. 2. During an interview on 2/24/2026 at 2:41 PM, Employee #1 said she did not know if the facility had liability insurance or where the documentation would be.	E 417		
E 418	0720-21-.04 (6)(f) Administration (6) Each home for the aged shall: (f) Keep a written up-to-date log of all residents and produce the log for the local fire department in the event of an emergency. This Rule is not met as evidenced by: Based on review of facility documentation and interview, the facility failed to maintain a written up-to-date log of all residents available to the local fire department in the event of an emergency. The findings included: 1. Review of facility documentation revealed the facility did not have an up-to-date log of all the residents. 2. During an interview on 2/24/2026 at 2:51 PM, Employee #1 said the facility did not have a written log of all the residents.	E 418		
E 508	0720-21-.05 (3)(f) Admissions, Discharges and Transfers (3) The home shall: (f) The Facility shall document evidence of annual vaccination against influenza for each resident, in	E 508		

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E 508	<p>Continued From page 5</p> <p>accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control most recent to the time of vaccine, unless such vaccination is medically contraindicated or the resident has refused the vaccine. Influenza vaccination for all residents accepting the vaccine shall be completed by November 30 of each year or within ten (10) days of the vaccine becoming available. Residents admitted after this date during the flu season and up to February 1, shall as medically appropriate, receive influenza vaccination prior to or on admission unless refused by the resident.</p> <p>The facility shall document evidence of vaccination against pneumococcal disease for all residents who are sixty five (65) years of age or older, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control at the time of vaccination, unless such vaccination is medically contraindicated or the resident has refused offer of the vaccine. The facility shall provide or arrange the pneumococcal vaccination of residents who have not received this immunization prior to or on admission unless the resident refuses offer of the vaccine.</p> <p>This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to document evidence of annual vaccination against influenza or a signed declination for 5 of 6 (Resident #1, #2, #3, #5 and #6) sampled residents reviewed for vaccination status.</p> <p>The findings included:</p> <p>1. Review of medical record for Resident #1</p>	E 508		

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E 508	<p>Continued From page 6</p> <p>revealed no documentation of an annual influenza vaccination or a signed declination.</p> <p>Review of medical record for Resident #2 revealed no documentation of an annual influenza vaccination or a signed declination.</p> <p>Review of medical record for Resident #3 revealed no documentation of an annual influenza vaccination or a signed declination.</p> <p>Review of medical record for Resident #5 revealed no documentation of an annual influenza vaccination or a signed declination.</p> <p>Review of medical record for Resident #6 revealed no documentation of an annual influenza vaccination or a signed declination.</p> <p>2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator said all the paperwork/resident records should be at the facility, and if it was not, she did not know what happened to the documentation. No documentation was provided by the facility for the vaccination status of the residents.</p>	E 508		
E 602	<p>0720-21-.06 (2) Personal Services</p> <p>(2) Medications shall be self-administered. If the home chooses to employ a currently licensed nurse, medications may be administered by the nurse.</p> <p>This Rule is not met as evidenced by: Based on medical record review and interview, the facility retained residents who had not been assessed to self-administer their own</p>	E 602		

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E 602	<p>Continued From page 7</p> <p>medications for 6 of 6 (Resident #1, #2, #3, #4, #5, and #6) sampled residents.</p> <p>The findings included:</p> <p>1. Review of the medical record revealed there was no assessment to determine if Resident #1 could self-administer medications.</p> <p>Review of the medical record revealed there was no assessment to determine if Resident #2 could self-administer medications.</p> <p>Review of the medical record revealed there was no assessment to determine if Resident #3 could self-administer medications.</p> <p>Review of the medical record revealed there was no assessment to determine if Resident #4 could self-administer medications.</p> <p>Review of the medical record revealed there was no assessment to determine if Resident #5 could self-administer medications.</p> <p>Review of the medical record revealed there was no assessment to determine if Resident #6 could self-administer medications.</p> <p>2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator stated all the paperwork/resident records should be at the facility, and if it was not, she did not know what happened to it.</p> <p>During interview on 2/24/2026 at 2:41 PM, Employee #1 stated the residents could not tell the name of their medications or what they were for. Employee #1 stated the caregiver at night put the resident's medications in a cup and gave the</p>	E 602		

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E 602	Continued From page 8 medications to the residents. During an interview on 2/25/2026 at 10:08 AM, Resident #1, # 2, and #5 each stated they did not know the name of their medications or why they took the medications. During an interview on 2/25/2026 at 10:29 AM, Resident #4 stated the night caregiver put his medications in a cup and gave it to him.	E 602		
E 609	0720-21-.06 (9) Personal Services (9) There must be a designated person responsible for the food service, including the purchasing of adequate food supplies and the maintenance of sanitary practices in food storage, preparation and distribution. Sufficient arrangements or employees shall be maintained to cook and serve the food. This Rule is not met as evidenced by: Based on review of facility documentation and interview, the facility failed to have a designated person responsible for food service. The findings included: 1. Review of facility documentation revealed the facility did not have a designated person responsible for food service. 2. During an interview on 2/24/2026 at 2:41 PM, Employee #1 stated the caregivers cooked the meals, but they did not follow any menus.	E 609		
E 610	0720-21-.06 (10) Personal Services	E 610		

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E 610	<p>Continued From page 9</p> <p>(10) Residents shall be provided at least three (3) meals per day. The meals shall constitute an acceptable diet. There shall be no more than fourteen (14) hours between the evening and morning meals. All food served to the residents shall be of good quality and variety, sufficient quantity, attractive and at safe temperatures. Prepared foods shall be kept hot (140°F or above) or cold (41°F or less). The food must be adapted to the habits, preferences, needs and physical abilities of the residents.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain food in good quality for 1 of 1 (2/24/2026) days of observation.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Observations in the kitchen on 2/24/2026 at 2:00 PM, revealed the following: <ol style="list-style-type: none"> a. 1 gallon container of mild salsa with expiration date of 10/22/2021 b. 1 gallon container of mild salsa with expiration date of 3/19/2023 c. 1-10 ounce can of sweet and sour sauce with expiration date of 9/27/2024 d. 1-8-ounce container of ranch spread/dip with expiration date of 12/4/2025 e. 1-10-ounce container of sweet relish with expiration date of 8/25/2018 f. 1 gallon container of 2% milk with expiration date of 1/22/2026 	E 610		

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E 610	<p>Continued From page 10</p> <p>g. 1 gallon container of 2% milk with expiration date of 6/8/2025</p> <p>h. 1 package of sugar cookie pancake mix with expiration date of 12/11/2024</p> <p>i. 3-32-ounce bags of pinto beans with expiration date of 8/11/2024</p> <p>j. 1-68 ounce of mushrooms with expiration date of 11/15/2022</p> <p>k. 1-bag of garbanzo chickpeas with expiration of 11/2/2023</p> <p>l. 1-3 pound can of sliced olives with expiration date of 3/4/2024</p> <p>m. 3-7.5-pound cans of jellied cranberry sauce with expiration dates of 4/25/2021, and 2/1/2023.</p> <p>n. 1-6.12-pound box of hominy with expiration date of 10/2024</p> <p>o. 1-16 ounce of corn mash flour with expiration date of 8/1/2024</p> <p>p. 3-13.25-ounce boxes of lasagna noodles with expiration date of 7/1/2025</p> <p>q. 1-6.2-ounce box of Rice a Roni with expiration date of 4/2/2021</p> <p>r. 1-4.6-ounce box of taco shells with expiration date of 11/24/2024</p> <p>2. During an interview on 2/24/2026 at 2:41 PM, Employee #1 confirmed the above food items were out of date.</p>	E 610		

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E 612	0720-21-.06 (12) Personal Services (12) A forty-eight (48) hour supply of food shall be maintained and properly stored at all times. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain and store a 48-hour supply of food/water in case of an emergency. The findings included: 1. Observations in the kitchen on 2/24/2026 at 11:30 AM, revealed there was no 48-hour supply of food and no 48-hour supply of water maintained in the facility for emergency use. 2. During an interview on 2/24/2026 at 2:41 PM, Employee #1 stated the facility did not have a 48-hour supply of food or water in case of an emergency.	E 612		
E 618	0720-21-.06 (18) Personal Services (18) The home must have a telephone accessible to all residents to make and receive personal telephone calls twenty-four (24) hours per day. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide a telephone accessible to all residents to make and receive personal telephone calls 24 hours per day. The findings included: 1. Observations in the common area on 2/24/2026 at 9:45 AM, revealed the facility did not	E 618		

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E 618	Continued From page 12 provide a telephone accessible to the residents for personal calls. 2. During an interview on 2/24/2026 at 2:41 PM, Employee #1 stated the facility did not have a telephone accessible to the residents. During an interview on 2/25/2026 at 9:40 AM, Resident #6's daughter stated she had sent the police out 3 days ago to check on her father. Resident #6's daughter stated the owner told her that she did not allow the residents to have cell phones, and there was no phone in the home for residents to use.	E 618		
E 826	0720-21-.08 (26)(a) Life Safety (26) The physical environment shall be maintained in a safe, clean and sanitary manner. (a) Any condition on the facility site conducive to the harboring or breeding of insects, rodents or other vermin shall be prohibited. Chemical substances of a poisonous nature used to control or eliminate vermin shall be properly identified. Such substances shall not be stored with or near food or medications. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe, clean physical environment for the residents. The findings included: 1. Observation in the facility's bathrooms on	E 826		

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL536519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2026
NAME OF PROVIDER OR SUPPLIER CANDLELITE 1		STREET ADDRESS, CITY, STATE, ZIP CODE 1042 MORTON STREET SHELBYVILLE, TN 37160		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 826	Continued From page 13 2/24/2026 at 3:00 PM, revealed the floors in the front bathroom on the left side of the house were unlevel and had a soft feeling when walking on them. The left front bathroom had broken tiles in front of the toilet, and there was black tape on the tile to hold them down. 2. During an interview on 2/24/2026 at 2:42 PM, Employee #1 confirmed the floor tiles were broken in front of the toilet in the left front bathroom.	E 826		
E1001	0720-21-.10 (1) (a) Records And Reports (1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include: (a) Name, Social Security Number, veteran status and number, marital status, age, sex, previous address and any health insurance provider and number, including Medicare and Medicaid numbers; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a resident file for 3 of 6 (Resident #2, #5 and #6) residents reviewed. The findings included: 1. Review of medical record for Resident #2 revealed no documentation of social security	E1001		

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL536519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2026
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E1001	Continued From page 14 name, veteran status and number, marital status, age, sex, previous address, and any health insurance provider or number. Review of medical record for Resident #5 revealed no documentation of social security name, veteran status and number, marital status, age, sex, previous address, and any health insurance provider or number. Review of medical record for Resident #6 revealed no documentation of social security name, veteran status and number, marital status, age, sex, previous address, and any health insurance provider or number. 2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator stated all the paperwork/resident records should be at the facility, and if it was not, she did not know what happened to it. The facility failed to provide any documentation for the residents' files.	E1001		
E1002	0720-21-.10 (1) (b) Records And Reports (1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include: (b) Name, address and telephone number of next of kin, legal guardian and any other person identified by the resident to contact on his/her behalf;	E1002		

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL536519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2026
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E1002	<p>Continued From page 15</p> <p>This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a resident file for 5 of 6 (Resident #1, #2, #3, #5 and #6) residents reviewed.</p> <p>The findings included:</p> <p>1. Review of the medical record for Resident #1 revealed no name, address and telephone number of next of kin, legal guardian or any other person identified by the resident to contact on his/her behalf.</p> <p>Review of the medical record for Resident #2 revealed no name, address and telephone number of next of kin, legal guardian or any other person identified by the resident to contact on his/her behalf.</p> <p>Review of the medical record for Resident #3 revealed no name, address and telephone number of next of kin, legal guardian or any other person identified by the resident to contact on his/her behalf.</p> <p>Review of the medical record for Resident #5 revealed no name, address and telephone number of next of kin, legal guardian or any other person identified by the resident to contact on his/her behalf.</p> <p>Review of the medical record for Resident #6 revealed no name, address and telephone number of next of kin, legal guardian or any other person identified by the resident to contact on his/her behalf.</p> <p>2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator stated all the</p>	E1002		

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL536519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2026
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NAME OF PROVIDER OR SUPPLIER CANDLELITE 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 MORTON STREET SHELBYVILLE, TN 37160
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E1002	Continued From page 16 paperwork/resident records should be at the facility, if it was not, she did not know what happened to it. The facility failed to provide any documentation of the residents' files.	E1002		
E1004	0720-21-.10 (1) (d) Records And Reports (1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include: (d) Date of admission, transfer, discharge and any new forwarding address; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a resident file for 5 of 6 (Resident #2, #3, #4, #5 and #6) residents reviewed. The findings included: 1. Review of the medical record for Resident #2 revealed no documentation of the date of admission. Review of the medical record for Resident #3 revealed no documentation of the date of admission. Review of the medical record for Resident #4 revealed no documentation of the date of admission.	E1004		

Health Facilities Commission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TNPL536519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2026
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NAME OF PROVIDER OR SUPPLIER CANDLELITE 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1042 MORTON STREET SHELBYVILLE, TN 37160
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E1004	Continued From page 17 Review of the medical record for Resident #5 revealed no documentation of the date of admission. Review of the medical record for Resident #6 revealed no documentation of date of admission. 2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator stated all the paperwork/resident records should be at the facility, and if it was not, she did not know what happened to it. The facility failed to provide any documentation of the residents' files.	E1004		
E1006	0720-21-.10 (1) (f) Records And Reports (1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include: (f) Record of all monies and other valuables entrusted to the home for safekeeping, with appropriate updates; This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a resident file for 5 of 6 (Resident #2, #3, #4, #5 and #6) residents reviewed. The findings included:	E1006		

Health Facilities Commission

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E1006	<p>Continued From page 18</p> <p>1. Review of the medical record for Resident #2 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home.</p> <p>Review of the medical record for Resident #3 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home.</p> <p>Review of the medical record for Resident #4 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home.</p> <p>Review of the medical record for Resident #5 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home.</p> <p>Review of the medical record for Resident #6 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home.</p> <p>2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator stated all the paperwork/resident records should be at the facility, and if it was not, she did not know what happened to it. The facility failed to provide any documentation of the residents' files.</p>	E1006		
E1007	<p>0720-21-.10 (1) (g) Records And Reports</p> <p>(1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the</p>	E1007		

Health Facilities Commission

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E1007	<p>Continued From page 19</p> <p>resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include:</p> <p>(g) Health information including all current prescriptions, major changes in resident's habits or health status, results of physician's visits, and any health care instructions; and</p> <p>This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain a resident file for 6 of 6 (Resident #1, #2, #3, #4, #5 and #6) residents reviewed.</p> <p>The findings included:</p> <p>1. Review of the medical record for Resident #1 revealed no documentation of health changes in the resident's habits, or health status, results of physician visits, or any health care instructions.</p> <p>Review of the medical record for Resident #2 revealed no documentation of health changes in the resident's habits, or health status, results of physician visits, or any health care instructions.</p> <p>Review of the medical record for Resident #3 revealed no documentation of health changes in the resident's habits, or health status, results of physician visits, or any health care instructions.</p> <p>Review of the medical record for Resident #4 revealed no documentation of health changes in the resident's habits, or health status, results of physician visits, or any health care instructions.</p> <p>Review of the medical record for Resident #5 revealed no documentation of health changed in</p>	E1007		

Health Facilities Commission

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

CANDLELITE 1

**1042 MORTON STREET
SHELBYVILLE, TN 37160**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E1007	<p>Continued From page 20</p> <p>the resident's habits, or health status, results of physician visits, and any health care instructions.</p> <p>Review of the medical record for Resident #6 revealed no documentation of health changed in the resident's habits, or health status, results of physician visits, and any health care instructions.</p> <p>2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator stated all the paperwork/resident records should be at the facility, and if it was not, she did not know what happened to it. The facility failed to provide any documentation of the residents' files.</p>	E1007		
E1008	<p>0720-21-.10 (1) (h) Records And Reports</p> <p>(1) An individual resident file shall be maintained for each resident in the home. Personal information shall be confidential and shall not be disclosed, except to the resident, the department and others with written authorization from the resident. These files shall be retained for one (1) year after the resident is transferred or discharged. The resident file shall include:</p> <p>(h) A copy of the admission agreement signed and dated by the resident.</p> <p>This Rule is not met as evidenced by: Based on medical record review and interview, the facility failed to have a signed admission agreement for 4 of 6 (Resident #2, #3, #5 and #6) residents reviewed.</p> <p>The findings included:</p> <p>1. Review of the medical record for Resident #2 revealed no signed admission agreement was</p>	E1008		

Health Facilities Commission

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E1008	<p>Continued From page 21</p> <p>obtained for the resident when admitted to the facility.</p> <p>Review of the medical record for Resident #3 revealed no signed admission agreement was obtained for the resident.</p> <p>Review of the medical record for Resident #5 revealed no signed admission agreement was obtained for the resident when admitted to the facility.</p> <p>Review of the medical record for Resident #6 revealed no signed admission agreement was obtained for the resident when admitted to the facility.</p> <p>2. During a telephone interview on 2/24/2026 at 9:40 AM, the Administrator said all the paperwork/resident records should be at the facility, and if it was not, she did not know what happened to it. The facility failed to provide any documentation of the residents' files.</p>	E1008		



Candlelite 1

Ms Mildred Thompson, Administrator

1042 Morton Street

Shelbyville, TN 37160

Via Email: mildredthompson37160@gmail.com Phone: 931-536-6047

Correspondence to: Attn: Amber X. Morris

Donald Milam: donaldmilam@tn.gov

Attn: Health Facilities Commission

West TN Regional Office

295 Summar Drive, 2nd Floor

amber.x.morris@tn.gov

Phone: 731-984-9684 Fax: 731-427-0407

Desk: 731-984-9718

www/tn.gov/hfc

Dear Ms Amber Morris and/or Mr Donald Milam

Enclosed is the Statement of Deficiencies resulting from the Licensure Survey and Complaint Investigation conducted at Candlelite 1 on March 3, 2026. Following your conversation with Ms. James, per your deadline, Ms Thompson has until **May 16, 2026 at 11:59 PM** to address the necessary deficiencies and develop a Plan of Correction (POC) in regards to both employee and the facility corrections of deficiencies.

In reference to, **RE: TNPL536519; RE: Licensure Survey/Complaint Investigation**. Below, you'll find the notes and corrections I need to make, along with the dates by which I can be completed by the POC.

Thank you, Amber, for the opportunity to resolve these issues and provide the State of Tennessee Health Facilities Commission, West Tennessee Regional Commission, with the necessary updates.

I would like you to understand that I have been unable to sign clearly with my dominant right hand. As a result, my signature may not be as legible as it once was. However, I am currently in therapy to address this issue.

Respectfully Submitted:

Mildred Thompson, Candlelite 1 Administrator

PLANS OF CORRECTIONS (2567 Form Response):

Employee Plan of Corrections

Subject: Development of a Comprehensive Plan of Correction for Deficiencies Cited in Tennessee Form 2567

Dear Ms Morris, and/or State of Tennessee Health Facilities Commission Office

I am reaching out to address the deficiencies identified in the recent State of Tennessee Form 2567 and to outline a detailed Plan of Correction (POC). Our commitment to compliance and quality improvement is paramount, and we intend to thoroughly address each cited issue.

Assessment of Deficiencies:

After a careful review of the deficiencies listed on the Form 2567, we have identified the following key areas requiring correction:

1. Compliance with Safety Protocols:

Several instances were noted where safety measures were not fully implemented, posing potential risks to staff and residents.

2. Documentation Accuracy:

Inconsistencies were found in the documentation of services provided, which undermines our accountability and quality of care.

3. Staff Training and Competency:

Gaps in training were highlighted, particularly concerning new regulations and protocols, which could impact staff performance and compliance levels.

Plan of Correction:

To effectively address these deficiencies, we have developed a detailed Plan of Correction that includes the following components:

1. Root Cause Analysis:

- A dedicated team will be established to investigate underlying reasons for each deficiency. This will involve interviews with staff and reviews of operational practices to pinpoint specific causes.

- The team will compile findings into a report that highlights key factors contributing to non-compliance.

2. Enhanced Training Programs:

- We will create an extensive training curriculum tailored to the identified deficiencies. This will include:

- Initial Training Sessions:

Comprehensive workshops focusing on safety protocols, documentation procedures, and compliance requirements will be held within the next 30 days.

- Regular Refresher Courses:

Bi-annual refresher sessions will be implemented to reinforce training and keep staff updated on new regulations.

- Competency Assessments:

Evaluations will be conducted following training sessions to ensure staff demonstrate understanding and practical application of the material.

3. Policy and Procedure Revisions:

- All relevant policies will be reviewed and updated to reflect current regulations and best practices. This will include:

- Clear guidelines on safety protocol implementation to ensure consistency across all departments.
- Standardized documentation practices that provide clarity on expectations and accountability.
- Staff will receive training on these updated policies to ensure everyone is aligned with the new standards.

4. Monitoring and Compliance Systems:

- A compliance monitoring system will be established, incorporating the following measures:
 - Regular Audits: Monthly audits will be conducted to assess adherence to policies, with findings documented and reported to management.
 - Compliance Metrics: Key performance indicators will be established to measure compliance over time and identify trends that require further attention.

Designated Compliance Officer:

Staff members will be assigned a compliance officer who will be responsible for ongoing monitoring and reporting on specific sections of the POC.

5. Feedback and Continuous Improvement:

- We will implement an anonymous feedback mechanism for staff to report any challenges or suggestions related to compliance, thereby fostering an open dialogue.
- A quarterly review meeting will be scheduled to discuss feedback results, assess progress on the Plan of Correction, and make necessary adjustments.

6. Timeline: A detailed timeline will be established for each component of the Plan of Correction, outlining start and completion dates. Deadline date for the following employee training to be administered by

For example:

- Root cause analysis: within 14 days
- Initial training sessions: within 30 days
- Policy revisions: within 45 days
- Establishing monitoring systems: within 60 days

7. Engagement with Regulatory Authorities:

We will maintain proactive communication with state regulators throughout the implementation process. Regular updates will be provided, and requests for feedback will be welcomed to ensure alignment with expectations.

By diligently implementing this Plan of Correction, we are committed to rectifying the cited deficiencies and enhancing our organizational practices. Our approach not only addresses immediate concerns but also aims to cultivate a culture of accountability and excellence in service delivery.

Thank you for your consideration and support as we work towards these important improvements. I look forward to discussing our progress and any further recommendations you may have.

Sincerely,

Mildred Thompson
Administrator

Candlelite 1

Telephone: (931) 536-6057

Plans of Corrections (Form 2567): The Facility – Building Deficiencies’ Response(s):

Response: E001 – 0720-21 Comments:

This Rule is not met as evidenced by:

An Annual survey and an investigation for complaint #TN00069071 was completed on June 01, 2026 at Candlelite 1. Deficiencies were cited related to the annual survey under Chapter 0720-21, Standards for Homes for The Aged.

Subject: Response to Initial Comments and Deficiencies

In writing to address the initial comments and submitted statements of deficiencies cited under complaint # TN00069071 on March 3, 2026 at Candlite 1. We want to express our gratitude for the feedback provided in the State of Tennessee form 2567 regarding our annual survey under Chapter 0720-21, Standards for Homes for the Aged.

As the Administrator, I take these deficiencies very seriously, and our team is committed to ensuring the highest standards of care for our residents. Below is our response to the noted deficiencies along with our proposed Plan of Correction:

Regarding the paperwork deficiencies noted during the recent telephone inperson visit on March 03, 2026. In response to your question, I want to clarify the Administrator's intent regarding the deficiencies. The Administrator intended for any deficiencies to be addressed and resolved promptly, ideally coinciding with the date of the on-site reevaluation. This approach will be aimed in ensuring that all necessary documentation is provided efficiently and in a timely manner.

Deficiency 1: Incomplete Paperwork

- **Response:** We appreciate the Administrator’s candid feedback regarding the state of our paperwork. We understand the importance of maintaining comprehensive documentation for compliance and operational efficiency.

- **Plan of Correction:** We will conduct a thorough audit of all existing paperwork by June 01, 2026 to identify gaps. Following the audit, we’ll implement a staff training session focused on proper documentation practices to ensure all paperwork meets required standards. Progress will be monitored through weekly reviews, led by the administrator, until all deficiencies are resolved.

Deficiency 2: Missing Records

- **Response:** Thank you for highlighting the absence of specific records. We acknowledge that missing documentation poses challenges to facility operations and compliance.

Plan of Correction: To rectify this, we will create a checklist of essential records that must be maintained. We will aim to compile all missing documents by date June 01, 2026. Additionally, we will establish a centralized filing system to streamline future record-keeping processes.

Deficiency 3: Policy Compliance

- **Response:** We recognize the necessity of adhering to established policies and appreciate the Administrator's guidance in this matter.

- **Plan of Correction:** Our corrective measures will include a review of all facility policies against current practices to identify any discrepancies. convene a staff meeting to ensure everyone is aligned with policy requirements going forward. Beginning the facilitate starting May 05, 2026, we will initiate weekly training sessions and conduct quality assurance audits to ensure adherence to all relevant standards.

This approach aims to proactively address potential issues and improve overall compliance. I look forward to seeing the positive effects of these initiatives on our operations, and convene with regular scheduled meeting monthly afterwards.

Response: E 402: 0720-21-04 (2) Administration

To clarify your question, I am the administrator responsible for managing all administrative tasks and exercising the powers of the licensee when they are unavailable. This role is crucial for ensuring our facility adheres to the required regulations, and I am dedicated to performing these duties with diligence. I assure you that all pertinent documentation will accurately represent this designation. The plan is to complete training by June 01, 2026.

Training for Employees #1 and #2

Training for Employee #1 will cover administrative processes, regulatory compliance, and the Quality Assurance Program. Employee #2's training will focus on monitoring protocols and reporting procedures. Each training session will include both theoretical and practical components, and training materials will be provided in advance to facilitate knowledge retention.

Documentation for Employee #1's Designation

The designation for Employee #1 to act on administrative matters is documented in writing, with a signed copy available in their personnel file.

Monitoring Process

Monitoring will occur bi-weekly, with results documented on a checklist. The Quality Assurance Manager will be responsible for this task, ensuring proper oversight and accountability.

Response: E 412: 0720-21-04 (5) Administration

Improvement Plan for Infection Control in Aged Care

1. Correction of Deficiencies: Each identified deficiency will be addressed through a comprehensive action plan. Staff will receive immediate training on the importance of the influenza vaccination program, and updated procedures will be implemented to ensure all staff are informed about vaccination options and requirements.
2. Timeline for Corrections: All deficiencies will be corrected by June 01, 2026 with immediate actions taken to educate staff and update records. Follow-up reviews will take place monthly until compliance is achieved.
3. Measures/Systematic Changes: A comprehensive tracking system for vaccination records and declination statements will be implemented. Regular workshops will be organized to emphasize the importance of vaccination, and alternative control measures will be clearly communicated to all employees. Enhanced communication protocols will be established to encourage staff participation in the vaccination program.
4. Monitoring and Quality Assurance: A quality assurance program will be instituted to regularly assess the effectiveness of the vaccination program. This will include quarterly audits of vaccination rates, monitoring of declination records, and feedback sessions to identify barriers to participation. A designated infection control officer will oversee the program and ensure compliance.
5. Documentation and Follow-Up: All actions taken will be documented, and follow-up assessments will be scheduled to ensure ongoing compliance with the vaccination program. Regular reports will be prepared for review by management to maintain accountability and continuous improvement. The plan is to complete all vaccinations with a scheduled appointment for each client by May 30, 2026.

Response: E 415 & 417: 0720-21- 04(6) (c) Administration

Regulation: Each home for older people shall maintain documentation of the checks of the "Registry of Persons who have Abused or Intentionally Neglected Elderly or Vulnerable Individuals" before hiring any employee.

Deficiency: The facility failed to complete the abuse registry checks for two employees (Employee #1 and Employee #2) prior to their hiring.

Response: Plan of Correction:

1. Immediate Actions Taken:

- a. Conductions of an internal review of current employee files to confirm completion of abuse registry checks for all employees.
- b. Initiated a corrective action plan to secure the necessary checks for Employee #1 and Employee #2 immediately.

2. Root Cause Analysis:

- a. Identified that the lack of documentation was due to procedural oversight in the hiring processes and insufficient staff training regarding documentation requirements.

3. Corrective Measures:

- a. Complete Abuse Registry Checks:
- b. Conductions of the required abuse registry checks for both Employee #1 and Employee #2 by, ensuring compliance with regulations by June 01, 2026.

4. Documentation Improvement:

- a. Established a standardized checklist for hiring documentation, which includes verification of the abuse registry check prior to any employee's start date.

Training:

Scheduled mandatory training sessions for all hiring managers and HR staff on the importance of compliance with abuse registry checks and proper documentation procedures by June 01, 2026.

1. Systemic Changes:

- Implemented a new electronic tracking system to monitor and maintain documentation of all required checks for current and future employees, with reminders set prior to hiring.
- Designated a Compliance Officer responsible for overseeing hiring procedures and maintaining up-to-date records of all abuse registry checks.

2. Monitoring:

- Conduct monthly audits of employee hiring files for six months to ensure compliance with the abuse registry checks.
- Review the effectiveness of new procedures and make necessary adjustments to the compliance plan during quarterly staff meetings.

Completion Date:

Tag 417: Monitoring Employee #2

Employee #2 will be monitored through regular audits and review of their logs and reports on monitoring activities. The Quality Assurance Manager will assess whether monitoring tasks are being executed as required.

- The above corrective measures will be completed by June 01, 2026 11:59 PM.

Please adjust any details as necessary to fit your specific circumstances and information.

E 418 0720-21-04 (6)(f) Administration

Plan of Correction: The contractor will complete all corrections by June 01, 2026, and the administrator will ensure compliance

Creation of Resident Log:

- On 06/01/2026 the task will be completed, a comprehensive written log of all residents will be established. This log includes up-to-date information such as names, room numbers, and emergency contacts for each resident. Corrections of activities required will be done by the staff and administrator by June 01, 2026.

Review of Log Accuracy:

- The facility management conducted an immediate audit of the new log to ensure accuracy and completeness. All caregivers will be involved in verifying the details.

Preventive Measures:

Regular Updates:

- A designated staff member will be assigned the responsibility of updating the resident log weekly or whenever there is a change in resident information, such as new admissions or discharges.

Training of Staff:

- All staff members will undergo training on the importance of maintaining an accurate resident log. This training will be scheduled for June 01, 2026 and will cover procedures for updating and accessing the log, as well as protocols for emergency situations.

Monthly Reviews:

- The facility management will implement monthly reviews of the resident log to ensure it is current and to provide additional oversight.

Emergency Preparedness:

Accessibility for Emergency Responders:

- The updated log will be stored in a designated area that is easily accessible to staff and local emergency responders. A copy of the log will be provided to the local fire department at the next scheduled emergency preparedness meeting.

Emergency Drills:

- The facility will incorporate drills that utilize the resident log to familiarize staff with emergency procedures, ensuring that all staff members are aware of how to quickly access and use the log in case of an emergency.

Monitoring and Compliance:

Quality Assurance:

- The facility will establish a Quality Assurance Committee that will meet quarterly to discuss compliance with the log maintenance and accuracy, and to address any issues that may arise.

The administrator intentions are to implemented these corrective actions, we aim to ensure compliance with regulations and enhance the safety of our residents. Regular updates and staff training will maintain the integrity of the resident log, thus improving our emergency preparedness.

**Plan of Correction: E 427 720-21-04 (7) Administration
Caregiver A (Employee#1 and B (Employee #2)**

Deficiency Reference: Up-to-date log of all residents not maintained.

1. Immediate Actions Taken: To have completed by **June 01, 2026.**

- On the day of the survey, a comprehensive list of all current residents was created and documented.

- Caregiver A and B was directed to ensure the immediate accuracy of the log and to include all pertinent information (name, room number, date of admission).

1. Systemic Changes:

- Daily Resident Log Maintenance:

- All caregivers will be responsible for updating the resident log daily. Changes in resident status (admissions, discharges, transfers) will be documented immediately and completed by **June 01, 2026.**

- A designated staff member will conduct a weekly review of the log to ensure accuracy.

2. Staff Training: Both A and B will be Training the following:

- A training session will be conducted for all staff on **June 01, 2026** regarding the importance of maintaining an up-to-date resident log and procedures for documentation.

- Staff will receive a copy of the updated policy and procedures regarding resident logs.

3. Emergency Preparedness:

- The resident log will be readily accessible and updated before each fire drill and emergency training session.
- A separate emergency contact list for each resident will be created and maintained alongside the log.

4. Monitoring Compliance:

- Weekly audits will be performed for the first three months following implementation of the corrective actions to ensure adherence to the new protocols.
- Audits will be reviewed during staff meetings, and any discrepancies will be addressed immediately.

5. Long-Term Plan:

- After three months, the facility will evaluate the effectiveness of the corrective actions taken and make adjustments as necessary.
- A policy review will take place quarterly to ensure ongoing compliance and improvements.

Follow-Up:

- The facility's management will conduct a follow-up evaluation on June 01, 2026 to assess the implementation of these corrective actions and their impact on resident log maintenance.

The plan aimed to address the identified deficiency effectively and ensure that all future documentation processes are compliant with regulatory standards.

E 508 0720-21-05 (3)(f) Administrative, Discharges and Transfers

Plan of Correction Response Per the Administrator (Ref#:1 through 6).

1. Correction of Deficiency:

The administrator will implement a comprehensive review of the current vaccination policy to ensure that all residents receive their annual influenza vaccinations by the designated deadline of May 30, 2026. This will include organizing additional vaccination days, ensuring adequate vaccine supply, and facilitating staff training on the importance of timely vaccinations.

2. Completion Dates for Each Deficiency:

- Vaccination Administration: All residents will have received their influenza vaccination by June 01, 2026.
- Documentation Review: Verification of vaccination records and completion of documentation will be finalized by June 01, 2026.

3. Measures/Systemic Changes to Prevent Recurrence:

- Regular Training Sessions: Monthly training for staff on vaccination protocols and the importance of annual vaccinations will be established.
- Vaccination Monitoring System: A tracking system will be put in place to monitor vaccination schedules and ensure timely administration of vaccines.
- Quality Assurance Audits: Quarterly audits will be conducted to evaluate vaccination compliance and address any issues that arise promptly.
- Resident and Family Engagement: Regular communication with residents and their families will be implemented to remind them of the vaccination schedule and its importance, fostering a culture of health and prevention.

Implementations of measures, we will ensure compliance with the State of Tennessee Health Facilities Commission requirements and enhance the overall health and safety of our residents.

Plan of Corrections

Tag 602: Resident Assessment: Caregiver A (Employee#1 and B (Employee #2)

The assessment of residents' ability to self-administer medications will include evaluating their cognitive ability, understanding of their medications, and any physical limitations impacting self-administration. If a resident is unable to self-administer medications, an alternative arrangement will be made, such as staff assistance.

Employees will be educated on the requirements for licensure/certification in the administration of medications. A clear distinction between assistance and administration has been conveyed through training sessions and written policies. Monitoring of employees will be conducted through direct observation and regular audits of medication records to ensure compliance with regulations. Completion Date of training: June 01, 2026.

E 609 0720-21-06 (9) Personal Services

Inclusions: Food Service Completion Date of Task required completed: June 01, 2026.

For the food service, the designated individual responsible will be the Food Service Manager, who will ensure that all aspects of food safety and service are adhered to. This responsibility will be documented in our staff roster and food service policy manual, which outlines roles and responsibilities clearly.

Tag 610: We will implement a strict inventory system to monitor food expiration dates. The kitchen staff will conduct weekly checks for expiration and will be responsible for disposing of any expired items. All findings will be documented on a food inventory log which will be reviewed monthly by the Food Service Manager to ensure compliance. Completion Date of Task required completed: June 01, 2026.

Tag 612: To maintain a 48-hour supply of food and water, we will conduct regular inventory assessments at least twice a week. The Food Service Manager will be responsible for monitoring

supplies and will keep a record of all supplies that are stocked, which will be stored in a dedicated inventory management system.

Tag 618: Enhanced communication protocols will include the installation of accessible telephones in common areas and clear access to personal cell phones for residents. Residents will be informed of their rights to use these communication tools during orientation and regularly through resident meetings. Completion date of task intended completed: June 01, 2026.

E 826 0720-21-08

Inclusions: Life Safety

Physical Environment Maintenance: Ensuring safety, cleanliness, and sanitary conditions across facilities.

Observations and Required Corrections

Location: Bathroom

1. Replacement of floor tiles is necessary.
2. Floors are uneven and require leveling, and soft area will be repaired.

Corrective Action Plan

In response to issues identified in E 826 0720-21-08 (specifically reports 609 and 826), the Administrator will implement the following corrective actions by June 01, 2026:

1. Bathroom:

- Replace damaged floor tiles.
- Level and restore the uneven flooring.

Follow-Up

The Administrator will conduct regular inspections following the completion of these corrective measures to ensure ongoing compliance with health and safety standards, with additional training provided to staff as necessary. The administrator will work to address all issues and concerns, ensuring clarity and accountability in the process.

Response: [E] 1001. All repairs for noted ID PREFIX TAG, administrator will have each individual repair issue repaired June 01, 2026 by contractor.

E 1001 Standards for Homes for the Aged:

E 1001: Standards for Homes for the Aged: Administer intends to correct noted deficiencies by June 01, 2026. In addition, both employees Employee #1 and Employee#2 will receive training to address the issues of matters of safety codes and safety precautions.

Observation of Correction Plan as follows: Monitoring and Reporting

- Responsibility: Assign a project manager to oversee all repairs and ensure that all tasks are completed by the specified date.
- Documentation: Keep a record of all repairs, inspections, and follow-up activities for accountability.

This plan will help address the observations effectively and ensure that all necessary repairs are completed on time.

Administrator will ensure compliance by regularly reviewing updates to the code and training team members on any newly instituted provisions. Regular audits will be conducted to identify areas for improvement and ensure adherence to both the NFPA 101 and local requirements.

Tags 1001, 1004, 1008: A plan of correction addressing these citations will be developed within the next 30 days, detailing specific actions we will take to resolve the issues noted.

Tags 1002, 1006, 1007: Employee #1 will conduct audits of resident records on a bi-weekly basis to ensure that all required information is included and accurate. Additionally, a designated supervisor will review these records quarterly to ensure compliance with state regulations.

The administration will encourage everyone to actively participate in these sessions, as your safety is our priority. Feedback from the training will be collected to continually improve our fire safety protocols. Completion of this training will be enforced by June 01, 2026, it crucial for ensuring the safety of all residents.

Response: The quarterly training on the fire safety procedures plan for 2026 is scheduled to be completed by June 01, 2026. This training will involve the participation of both the administrator and all staff members to ensure comprehensive understanding and compliance. Results from the training will be reviewed collectively to identify areas for improvement and enhance our fire safety protocols. Completion date by June 01, 2026.

E 1001: 0720-21-10 (1) (a) Records and Reports

Resident #2 – Medical Records Health Records/ Social Security Number

Response: Record currently available.

Plan of Correction for Non-Availability of Medical Records and Social Security for Resident #2

Objective: To address the issues pertaining to the unavailability of medical records and Social Security documentation for Resident #2 and ensure that similar occurrences do not happen in the future.

Action Steps: Plan of Corrections and Training; within 30 days or by June 01, 2026.

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1. **Assessment of Current Procedures:**

Review existing protocols for handling and storing medical records and Social Security documentation. Identify gaps in the current system that led to the non-availability for Resident #2.

2. **Staff Training:**

Conduct training sessions focused on the importance of maintaining accurate and accessible medical records and Social Security information.

The administrator will introduce best practices for record-keeping and documentation, including proper filing, regular audits, and timely updates.

3. **Implement a Tracking System:**

Develop a tracking system to monitor the status and availability of essential records for each resident. Assign responsibility to designated staff members for regular checks and updates to ensure all documentation is current and accessible.

4. **Regular Audits:**

Schedule periodic audits of medical records and Social Security documents to verify their completeness and accuracy. Address any discrepancies immediately and implement corrective measures.

5. **Feedback Mechanism:**

Establish a system for staff to report any challenges or issues they encounter concerning records management. Regularly review feedback to make improvements and adjustments to existing processes.

6. **Follow-Up and Evaluation:**

Set a timeline for follow-up evaluations to assess the effectiveness of the implemented measures. Make necessary adjustments based on the evaluation outcomes to continually enhance the systems in place.

Goal: To ensure that the necessary medical records and Social Security information for all residents, including Resident #2, are consistently available and accurately maintained, preventing recurrence of such issues in the future; by June 01, 2026 completion.

Records and Reports: Individual Reports, each separately discussed. Inclusions: Inclusions of Resident(s): #2, #3, #5, #6. Expected completion date: June 01, 2026 for each resident.

Resident: #2

Records and Reports: Date to be completed:

May 30, 2026 for each resident.

- 1) **Files should be retained for one year of the resident#2 (his/her).**

E1002 0720-21-10 (1) (b) within 30 days or by June 01, 2026

(b) Information needed: Expected completion date: June 01, 2026. for each resident, within 30 days.

E 1004 0720-21-10 (1) (d) Within 30 days or by June 01, 2026

E1005 0720-21-10 (1)(e):

Review of medical record Resident#2 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home. Completion Date to complete: May 30, 2026 for each resident.

E1007 0720-21-10 (1) (g):

Review of medical record for Resident#2 revealed no documentation of health changes in the resident's habits, or health status, results of physician visits, and any health care instructions. June 01, 2026 for each resident.

E1008 0720-21-10 (1) (h): Completion date to complete by June 01, 2026, within 30 days or by May 30, 2026

Review of medical record for Resident#2, no admit date in records, revealed no signed admission agreement was obtained for the resident when admitted to the facility.

Resident: #3: Expected completion date of : Date intended to complete by: June 01, 2026. for each resident.

E1002 0720-21-10 (1) (b)

(b) Information needed:

- 1) Name**
- 2) Address**
- 3) Telephone number of next to kin**
- 4) Legal guardian**
- 5) Any other person identified by the resident to contact on his/her behalf.**

E 1004 0720-21-10 (1) (d)

Need of a resident file

E1005 0720-21-10 (1)(e): Review of medical record Resident#3 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home.

E1007 0720-21-10 (1) (g):

Review of medical record for Resident#3 revealed no documentation of health changes in the resident's habits, or health status, results of physician visits, and any health care instructions.

E1008 0720-21-10 (1) (h): Expected completion date: June 01, 2026 for each resident.

Review of medical record for Resident#3, no admit date in records, revealed no signed admission agreement was obtained for the resident when admitted to the facility.

Resident: #5 Expected completion date: June 01, 2026 for each resident, within 30 days or by May 30, 2026

E1002 0720-21-10 (1) (b)

(b) Information needed: Expected completion date: June 01, 2026 for each resident.

- 1) Name**
- 2) Address**
- 3) Telephone number of next to kin**
- 4) Legal guardian**
- 5) Any other person identified by the resident to contact on his/her behalf.**

E 1004 0720-21-10 (1) (d): Expected completion date: June 01, 2026 for each resident.

Need of a resident file

E1005 0720-21-10 (1)(e): Expected completion date: June 01, 2026 for each resident.

Review of medical record Resident#5 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home

E1007 0720-21-10 (1) (g): Expected completion date: June 01, 2026 for each resident.

Review of medical record for Resident#5 revealed no documentation of health changes in the resident's habits, or health status, results of physician visits, and any health care instructions.

E1008 0720-21-10 (1) (h): Expected completion date: June 01, 2026.

Review of medical record for Resident#5, no admit date in records, revealed no signed admission agreement was obtained for the resident when admitted to the facility.

Resident: #6: Expected completion date: May 30, 2026 for each resident. Each Tag# E10020720-21-10 (1) (b), E 1004 0720-21-10 (1) (d), E1005 0720-21-10 (1)(e), E1007 0720-21-10 (1) (g), E1008 0720-21-10 (1) (h): June 01, 2026.

E1002 0720-21-10 (1) (b):

(b) Information needed:

- 1) Name**
- 2) Address**
- 3) Telephone number of next to kin**
- 4) Legal guardian**
- 5) Any other person identified by the resident to contact on his/her behalf.**

E 1004 0720-21-10 (1) (d): Expected completion date: June 01, 2026 for each resident.

Based on medical record review and interview the facility failed to maintain a resident#6, E 1004 0720-21-10 (1) (d)
Need of a resident file.

E1005 0720-21-10 (1)(e): Expected completion date: June 01, 2026 for each resident.

Review of medical record Resident#6 revealed no name of preferred physician, hospital, pharmacist, assisted care living facility and nursing home.

E1007 0720-21-10 (1) (g): Expected completion date: June 01, 2026 for each resident.

Review of medical record for Resident#6 revealed no documentation of health changes in the resident's habits, or health status, results of physician visits, and any health care instructions.

E1008 0720-21-10 (1) (h): Expected completion date: June 01, 2026 for each resident.

Review of medical record for Resident #6, no admit date in records, revealed no signed admission agreement was obtained for the resident when admitted to the facility.

**Plan of Correction: Response
Plan of Action**

Objective: To ensure compliance with state regulations and improve the quality of food service and safety protocols within our facility.

1. Designated Responsibility for Food Service (Tag 609)

Action:

- Appoint Food Service Manager: Designate a qualified individual as the Food Service Manager.
- Documentation: Update internal policy manuals to reflect this appointment, ensuring all staff are aware of roles and responsibilities.
- Timeline: Immediately and by May 21, 2026 and continue ongoing daily.

2. Management of Expired Food Items (Tag 610) Expected completion date: within 30 days or by June 01, 2026

Action:

- Inventory System Implementation: Create a tracking system for food items with expiration dates, including a checklist for weekly verification.
- Staff Training: Train kitchen staff on proper inventory monitoring and disposal procedures for expired items.
- Record Keeping: Maintain a food inventory log that will document all checks and disposals.
- Timeline: June 30, 2026.

3. 48-Hour Supply of Food and Water (Tag 612) Completion and within 14 days and/or June 01, 2026

Action:

- Regular Supply Checks: Establish a protocol for inventory checks twice a week to ensure a sufficient supply of food and water.
- Documentation Protocol: Create a supply log that must be completed and signed by the Food Service Manager after each check.
- Timeline: Begin within 14 days and ongoing thereafter or by June 01, 2026.

4. Enhanced Communication Protocols (Tag 618)

Action:

- Install Telephones: Ensure that telephones are accessible in common areas.
- Policy Communication: Update resident handbooks to clearly state policies on communication, including the use of personal cell phones.
- Resident Meetings: Hold a meeting to explain communication options available to residents.
- Timeline: June 01, 2026.

5. Addressing Safety Concerns (Tag 826)

Action:

- Maintenance Request System: Develop a formal process for staff to report maintenance issues to the Maintenance Supervisor.
- Documentation of Suggestions: Create a suggestion logbook for residents to document their feedback and concerns.
- Staff Training: Provide staff training on how to use the reporting system effectively.
- Timeline: Implement within June 01, 2026.

6. Citations Action Plan (Tags 1001, 1004, 1008)

Action:

- Develop Plan of Correction: Create a detailed plan for each citation, outlining corrective actions and timelines for completion.
- Review and Approval: Submit the plan to appropriate governing body for review and approval.
- Timeline: Complete within 30 days.

7. Auditing Resident Records (Tags 1002, 1006, 1007)

Action:

- Audit Schedule: Establish a bi-weekly schedule for Employee #1 to audit resident records.
- Quarterly Review Platform: Designate a compliance supervisor to conduct quarterly reviews for accuracy and completeness of records.
- Timeline: Start auditing within 14 days, completed by June 01, 2026 and continue ongoing.

Monitoring and Evaluation:

- Regular Reviews: Conduct monthly reviews of all actions taken to ensure compliance with state regulations.
- Feedback Loop: Implement a system for receiving feedback from staff and residents regarding the effectiveness of the actions taken.

Responsible Parties: Designate Employee#1 and Employee#2 for each action area to ensure accountability.

Reporting: Create a reporting mechanism for summarizing progress on the action items to be shared with management and regulatory bodies as required.