STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445187	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Tennessee Post Acute	597 West Forest Avenue Jackson, TN 38301

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 interview, the facility failed to promote and ensure residents were treated with dignity and respect for 2 of 54 (Resident #25 and #33) sampled residents reviewed for resident rights. The findings include: 1. Review of the facility policy titled, Resident Rights, dated February 2021, revealed .Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .a dignified existence .be treated with respect, kindness, and dignity .privacy . 2. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Myasthenia Gravis (a chronic autoimmune disorder with weakness), Gastrostomy (a tube inserted into the stomach for the administration of nutrients or medications), Malnutrition, and Depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #25 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was cognitively intact. Review of the Physician's Order dated 6/12/2026, revealed Miconazole Nitrate 2% Vaginal ointment (used to treat an antifungal rash) insert 1 application two times daily. Observation during medication administration on the 100 Hall Medication cart on 6/16/2026 at 8:18 AM, revealed Licensed Practical Nurse (LPN) B gathered supplies to administer Miconazole vaginal cream to Resident #25. LPN B entered the room, donned clean gloves, removed Resident #25's brief, administered the Miconazole vaginal cream to the resident's labia. LPN B exited Resident #25's room and returned to the 100 B med cart. LPN B failed to provide privacy during the administration of a vaginal medication when she failed to close the blinds on the resident's window to the outside. During an interview on 6/16/2026 at 8:40 AM, LPN B was asked if the blinds should have been closed to the resident's window prior to the administration of the vaginal cream. LPN B stated, Yes. During an interview on 6/16/2026 at 10:38 AM, the Director of Nursing (DON) was asked if the resident's blinds should be closed for privacy prior to the administration of medications. The DON stated, Yes. 3. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease, Diabetes, and Dementia. Review of the Medicare 5-day MDS assessment dated [DATE], revealed Resident #33 scored a 5 on the BIMS assessment, which indicated he was severely cognitively impaired. Resident #33 was assessed for the use of an indwelling urinary catheter (a device that drains urine from your urinary bladder into a collection bag outside of your body). Review of the Care plan dated 6/4/2026, revealed .has an Indwelling Catheter . Review of the Physician's Orders dated 6/4/2026, revealed CATHETER .Indwelling Foley Catheter .Check placement and patency Q [every] daily. every morning and at bedtime for urinary retention . Review of the Physician's Orders dated 6/4/2026, revealed . CATHETER: Indwelling urinary (Foley) catheter is in privacy bag, check for placement Q shift . Observation in Resident #33's room on 6/15/2026 at 8:53 AM, 10:30 AM, and 2:03 PM, revealed Resident was lying in bed with his foley catheter bag hanging on the bedframe on the right side visible from the door and hallway. The foley catheter bag did not have a privacy bag covering it. Observation and interview in the doorway of the resident's room on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/15/2026 at 2:07 PM, revealed LPN C was asked to look at Resident #33's foley catheter bag. LPN C was asked if the foley catheter bag should have a privacy bag over it since it is visible from the door of the room. LPN C stated, Yes. I will get one now. During an interview on 6/16/2026 at 3:01 PM, the DON was asked if she would expect staff to provide a privacy bag for a foley catheter. The DON stated, Yes, I would. The DON was asked if she expected Physician Orders to be followed. The DON stated, Yes.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to follow physician's orders to meet professional standards of practice for 2 of 6 (Residents #18 and #53) sampled residents and the facility failed to revise the care plan for 1 of 6 (Resident #53) sampled residents reviewed for unnecessary medications. The findings include: 1. Review of the facility policy titled, Administering Medications, dated April 2019, revealed .Medications are administered in a safe and timely, manner and as prescribed .Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions .The following information is checked/verified .Vital signs, if necessary .The individual administering the medication initials the residents MAR [Medication Administration Record] after giving the medication . Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated March 2022, revealed .The comprehensive, person-centered care plan .describes the services that are to be furnished to attain or maintain the resident's highest practicable .mental, and psychosocial well-being .reflects currently recognized standards of practice for problem areas and conditions . 2. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dementia, and Depression. Review of the signed physician orders dated 4/2026, revealed .Colace [for constipation] .one time a day .Aspirin [clot prevention] .1 tablet by mouth one time day .Caltrate [supplement] .1 tablet .one time a day .Cholecalciferol [supplement] 1 capsule .1 time a day .Fluticasone Propionate Nasal Suspension [for allergies] .every morning .Levocetirizine Dihydrochloride [for allergies] 1 tablet .one time a day .Lidocaine .Cream .every morning .Meloxicam [for pain] 1 tablet .one time a day .Metformin [for increased blood sugar] .1 tablet .one time a day .Metoprolol Tartrate Tablet [for hypertension] .every morning .Oxybutynin[used to treat overactive bladder] .1 tablet .one time a day .Pregabalin [for pain] .every morning . Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #18 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated she was cognitively intact. Resident #18 received Antianxiety, Antiplatelet, Hypoglycemic, and Anticonvulsants medications. Review of the Medication Administration Record (MAR) dated April 26, 2026, revealed the following medications were not documented as being administered: a. Aspirin b. Caltrate c. Cholecalciferol d. Levocetirizine e. Meloxicam f. Metformin g. Oxybutynin h. Colace i. Fluticasone j. Lidocaine-Prilocaine k. Metoprolol Tartrate l. Pregabalin 3. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE], with diagnoses including Spinal Stenosis, Congestive Heart Failure, Hypertension, Overactive Bladder, Bipolar Disorder, Diabetes, Chronic Obstructive Pulmonary Edema, Anxiety and Depression. Review of the Care Plan dated 4/10/2026, revealed the facility failed to care plan an antipsychotic medication. Review of the admission MDS assessment dated [DATE], revealed Resident #53 scored a 14 on the BIMS assessment, which indicated that she was cognitively intact. Resident received antianxiety, antidepressant, opioids and anticonvulsant medications. Review of the signed physician orders dated 4/2026, revealed .Buspirone [for anxiety] .Oral Tablet .three times a day .Oxybutynin [for over active bladder] .Oral Tablet .one time day .Gabapentin [for pain] Capsule .three times a day .Vraylar [used for bipolar] Oral Capsule .one time a day .Fluoxetine oral capsule [for Bipolar] .one time a day .Carvedilol Oral Tablet [treatment for high blood pressure] .two times a day . Review of the MAR dated April 26, 2026, revealed the following medications were not documented as being administered: a. Fluoxetine b. Oxybutynin c. Vraylar d. Carvedilol e. Buspirone f. Gabapentin During an interview on 6/17/2026 at 10:20 AM, the MDS Coordinator was asked if antipsychotics should be care planned, the MDS Coordinator stated, Yes, let me fix that . 4. During an interview on 6/17/2026 at 10:40 AM, the Director of Nursing (DON) was asked if Residents should receive medications as ordered. The DON stated, Yes . The DON was asked if Resident #18 and #53 received their morning medication on 4/26/2026. The DON stated, No .not documented means wasn't (continued on next page)

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West Tennessee Post Acute	597 West Forest Avenue Jackson, TN 38301

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	done. The DON was asked if an antipsychotic medication should be care planned. The DON stated, Yes.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility policy review, medical record review, observations, and interview, the facility failed to ensure infection control practices to prevent the spread of communicable diseases when 2 of 10 staff (Certified Nursing Assistant (CNA) A and Licensed Practical Nurse (LPN) B) failed to store and use personal protective equipment (PPE) for 2 of 2 (Resident #8 and Resident #25) sampled residents reviewed for transmission based precautions (TBP) and enhanced barrier precautions (EBP). The findings include: 1. Review of the facility policy titled, Isolation-Categories of Transmission-Based Precautions, dated September 2022, revealed .Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection.Standard precautions are initiated when caring for residents at all times regardless of their suspected or confirmed infection status.The facility makes every effort to use the least restrictive approach to manage individuals with potentially communicable infections.Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with resident or indirect contact with environmental surfaces or resident-care items in the resident's environment.Staff and visitors wear a disposable or washable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed.Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.Chronic wounds and/or indwelling medical devices even if the resident is known to be infected or colonized with MDRO [Multi Drug Resistant Organism]. Review of the facility's policy titled, Handwashing/Hand Hygiene, dated 8/2019, revealed .This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .Use an alcohol-based hand rub .or soap .and water for the following situations .Before and after direct contact with residents .after removal of gloves .Washing hands .use a clean towel to turn off the faucet . 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Urinary Tract Infection (UTI), Bacteremia (bacteria present in the bloodstream), Anxiety, and Depression. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was moderately cognitively impaired. Review of the Physician Order dated 6/12/2026, revealed .Place resident under isolation per CDC [Centers for Disease Control] guidelines and follow transmission based precautions. CONTACT isolation for ESBL [Extended-Spectrum Beta-Lactamase is antibiotic-resistant bacteria requiring special infection precautions and treatment] + [positive] urine. Observation during dining on the 200 B Hall on 6/15/2026 at 11:47 AM, revealed CNA A donned a gown and gloves prior to entering Resident #8's room. CNA A assisted with tray set up for Resident #8. CNA A removed the soiled gown and gloves and placed the gown in the floor prior to exiting the Resident's room. During an interview on 6/15/2026 at 11:58 AM, CNA A was asked what should she have done with gown when leaving a contact isolation room. CNA stated, I should have put it in the biohazard bag but I put it in the floor. CNA A was asked should the gown have been placed in the floor. CNA A stated, No. During an interview on 6/17/2026 at 8:39 AM, the Director of Nursing (DON) was asked what should staff do when they remove a gown prior to exiting a contact isolation room. The DON stated, They should put it in a red bag to take to laundry. The DON was asked if they should put the soiled gown in the floor. The DON stated, No. 3. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Myasthenia Gravis (Chronic autoimmune disorder with weakness), Gastrostomy tube (a tube inserted into the stomach for the administration of nutrients or medications), Malnutrition, and Depression. Review of the Physician's Order dated 6/5/2026, revealed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Enhanced Barrier Precautions during high contact time. Review of the Physician's Order dated 6/7/2026, revealed the following medications may be administered slow push via (by way of) gastrostomy tube as needed: a. Escitalopram Oxalate (used to treat Depression)10 milligram (mg) one time a day. b. Bethanechol Chloride (used to treat urinary retention) 25mg twice daily. c. Midodrine (used to treat low blood pressure) 5mg three times daily. d. Dronabinol (used to stimulant appetite) 2.5mg two times daily. Review of the admission MDS assessment dated [DATE], revealed Resident #25 scored a 14 on the BIMS assessment, which indicated she was cognitively intact. Review of the Physician's Order dated 6/12/2026, revealed Miconazole Nitrate 2% Vaginal ointment (used to treat antifungal rash) insert 1 application two times daily. Observation during medication administration on 6/16/2026 at 8:18 AM, LPN B entered Resident #25's room. LPN B removed Resident #25's brief, administered the Miconazole vaginal cream to vaginal labia with her right gloved hand. LPN B removed her right glove, donned a new glove without performing hand hygiene and recapped the tube of ointment. LPN B removed the gloves, performed hand hygiene at the bathroom sink and turned the faucet off with her barehand. LPN B exited Resident #25's room and returned to the medication cart. LPN B then prepared the following medications: Escitalopram Oxalate 10mg 1 tab, Bethanechol Chloride 25mg 1 tab, Midodrine 5mg 1 tab. Dronabinol 2.5mg 1 cap from the 100B medication cart. LPN B crushed and administered medications via g-tube (gastrostomy tube) separately by gravity without donning appropriate PPE (gown) in accordance with the facility policy for EBP. Dronabinol 2.5mg 1 capsule was administered by mouth. LPN B failed to perform proper hand hygiene during medication administration and failed to don a gown prior to the administration of medications via gastrostomy tube. During an interview on 6/16/2026 at 8:40 AM, LPN B was asked if PPE should have been worn during the medication administration for Resident #25. LPN B stated, No, only if there is a sign on the door. LPN B was asked if there was a sign for Resident #25. LPN B stated, Yes. LPN B was asked what residents should have EBP. LPN B stated, [Residents with] Wounds and Infections. LPN B was asked what about residents with tubes or lines. LPN B stated, Yes. LPN B was asked should PPE been worn when administering medications to the resident with g-tube medications. LPN stated, Yes. LPN B was asked should she have worn a gown during medication administration to of peg [gastrostomy] tube medications. LPN B stated, Yes. During an interview on 6/16/2026 at 10:38 AM, the DON was asked when should staff wear PPE for EBP. The DON stated, With direct contact care for residents with indwelling medical devices, a MDRO, a wound, a peg tube. During an interview on 6/17/2026 at 10:48 AM, the DON was asked when should staff perform hand hygiene. The DON stated, Before entering [Resident] rooms and before and after the removal of gloves. The DON was asked if staff should turn the faucet off with their barehand after performing hand hygiene. The DON stated, No, with a paper towel. The DON was asked what PPE should be worn for EBP. The DON stated, A gown and gloves.