

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445330	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Covington Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 765 Bert Johnston Avenue Covington, TN 38019	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, the facility's shower schedule review, observation, and interview, the facility failed to ensure Activities of Daily Living (ADL) assistance was provided related to showering and personal hygiene care for 3 of 4 (Resident #2, #8 and #67) sampled residents reviewed for ADLs. The findings include: 1. Review of the facility's policy titled, Activities of Daily Living, dated 3/2018, revealed Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. hygiene [bathing, dressing, grooming.]. Review of the undated facility's policy titled, Resident [NAME] of Rights, revealed It is designed to ensure that residents receive care that respects their dignity. Each Resident shall have the right to. The right to receive the services and/or items included in plan of care. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Mild Cognitive Impairment, Other Lack of Coordination, and Muscle Weakness with Need for Assistance with Personal Care. Review of the Care Plan dated 12/17/2025, revealed Resident #2 had an ADL Self Care deficit and required staff assistance with ADLs. Review of the significant change Minimum Data Set (MDS) assessment dated 12/24/2025, revealed Resident #2 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was cognitively intact. The MDS revealed it was very important for resident to choose between a tub bath, shower, bed bath, or sponge bath. Resident #2 required partial to moderate assistance with showering and required supervision to touch assistance with personal hygiene. Review of the facility's Shower Schedule revealed Resident #2 was scheduled to receive a shower on every Monday, Wednesday and Friday on the 6:00 AM- 6:00 PM shift. Review of the Follow Up Question Report (a sheet that showed documentation of showers received) dated December 2025, revealed Resident #2 did not receive a shower on the following scheduled dates: a. 12/19/2025 b. 12/21/2025 c. 12/26/2025 d. 12/28/2025 e. 12/30/2025 Review of the Follow Up Question Report dated January 2026, revealed Resident #2 did not receive a shower on the following scheduled dates: a. 1/2/2026 b. 1/5/2026 c. 1/7/2026 d. 1/10/2026 e. 1/14/2026 f. 1/16/2026 g. 1/21/2026 h. 1/23/2026 i. 1/26/2026 j. 1/28/2026 k. 1/30/2026 Review of the Follow Up Question Report dated February 2026, revealed Resident #2 did not receive a shower on the following scheduled dates: a. 2/2/2026 b. 2/4/2026 c. 2/6/2026 d. 2/9/2026 e. 2/11/2026 f. 2/13/2026 g. 2/16/2026 h. 2/28/2026 i. 2/20/2026 j. 2/23/2026 k. 2/25/2026 l. 2/27/2026 Review of the Follow Up Question Report dated March 2026, revealed Resident #2 did not receive a shower on the following scheduled dates: a. 3/2/2026 b. 3/4/2026 c. 3/6/2026 d. 3/9/2026 e. 3/11/2026 f. 3/13/2026 g. 3/16/2026 h. 3/18/2026 i. 3/20/2026 j. 3/23/2026 Review of Resident #2's shower documentation revealed, the resident only received 4 showers from 12/17/2025 - 3/25/2026. During an interview on 3/23/2026 at 10:13 AM, Resident #2 stated, I have not received a shower but about 4 times since I've been here. When asked if he had spoken to anyone regarding the concern, the resident (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>stated, I told a Nurse, but no one has done anything. During an interview on 3/24/2026 at 11:56 AM, Resident#2 stated that he requested a shower today and was also waiting on the Certified Nursing Assistant (CNA) to assist. During an interview on 3/24/2026 at 3:22 PM, Resident #2 was asked if he had received his shower that was requested. Resident #2 stated, I haven't. I spoke with the Nurse down there and she act like she didn't know what I was talking about.I would still like my shower today. During an interview on 3/25/2026 at 8:49 AM, CNA A stated that she is responsible for performing a shower on Resident #2. CNA A explained that on most days she does not have enough time to complete her assigned showers. CNA A was asked how many times he was to receive a shower. CNA A stated, I think two times a week. CNA A proceeded to review assignment packet and noted that Resident #2 was noted three times a week. When asked the last time Resident #2 received a shower, CNA A stated, I have to be honest, the last time I gave him a shower was about 3 weeks ago. During an interview on 3/25/2026 at 9:33 AM, the Administrator and Director of Nursing (DON) confirmed bed baths are done daily when they don't receive a shower. Residents are to receive a shower 3 days a week. The DON and Administrator were asked if residents should receive showers on their assigned shower days. The Administrator stated, Yes, absolutely. The Director of Nursing stated, I agree. 3. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Dysphagia, Malnutrition, Seizures, and Gastrostomy (a feeding tube placed into the stomach for nutritional supplements or medication administration) status. Review of the Care Plan dated 5/12/2025, revealed .The resident needs total assist for bathing . Review of the significant change MDS assessment dated [DATE], revealed Resident #8 scored a 15 on the BIMS assessment, which indicated he was cognitively intact. Resident #8 was dependent on staff with activities of daily living (ADLs). Review of the facility's Shower Schedule revealed Resident #8 was scheduled to receive showers on day shift every Tuesday, Thursday, and Saturday. Review of Resident #8's ADL bathing task dated 1/2026, revealed Resident #8 did not receive a bath or shower on the following dates scheduled: a. 1/6/2026 b. 1/10/2026 c. 1/13/2026 d. 1/15/2026 e. 1/20/2026 f. 1/24/2026 g. 1/27/2026 Review of Resident #8's ADL bathing task dated 2/2026, revealed Resident #8 did not receive a bath or shower on 2/21/2026 as scheduled. Review of Resident #8's ADL bathing task dated 3/2026, revealed Resident #8 did not receive a bath or shower on the following dates as scheduled: a. 3/6/2026 b. 3/8/2026 c. 3/17/2026 During an observation and interview in the resident's room on 3/23/2026 at 10:57 AM, Resident #8 was resting in bed watching television with bed in lowest position, blinds closed, a strong foul body odor was noted in the resident's room. Resident #8 was asked if he gets his showers/baths like he is scheduled. Resident #8 stated, No. During an observation in Resident #8's room on 3/23/2026 at 2:13 PM, revealed Resident #8 was asleep in bed with bed in lowest position and a strong foul body odor noted in the resident's room. 4. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Traumatic Brain Injury, Malnutrition, and Dementia. Review of the Care Plan dated 7/9/2025, revealed .The resident needs mod [moderate] to max [maximum] for bathing . Review of the annual MDS assessment dated [DATE], revealed Resident #67 scored a 13 on the BIMS assessment, which indicated she was cognitively intact. Resident #67 was dependent on staff with ADLs. Review of the facility's Shower Schedule revealed Resident #67 was scheduled to receive showers on day shift every Tuesday, Thursday, and Saturday. Review of Resident #67's ADL bathing task dated 1/2026, revealed Resident #67 did not receive a shower or bath on 1/13/2026 as scheduled. Review of Resident #67's ADL bathing task dated 2/2026, revealed Resident #67 did not receive a shower or bath on 2/21/2026 as scheduled. Review of Resident #67's ADL bathing task dated 3/2026, revealed Resident #67 did not receive a shower or bath on the following scheduled dates. a. 3/12/2026 b. 3/17/2026 c. 3/20/2026 During an observation and interview in Resident #67's room on 3/23/2026 at 9:39 AM, revealed Resident #67 resting in bed. Resident stated, I do not get 3 baths a week, sometimes I only get one a week. Resident #67 was asked if she had mentioned to anyone about her not receiving her baths as scheduled. Resident #67 (continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>stated, Yes, but it didn't matter. During an interview on 3/25/2026 at 8:03 AM, the DON was asked what days Resident #8 and Resident #67 are scheduled to get showers. The DON stated, On day shift every Tuesday, Thursday, and Saturday. The DON was asked if the residents are scheduled to get their scheduled showers on those days should they get them and should it be documented. The DON stated, Yes, but they could have refused. The DON was asked if the resident refused should the documentation not reflect the resident's refusal instead of not applicable or activity did not occur without explanation. The DON stated, Yes, if the resident refused the documentation should reflect refusal and NA is not appropriate documentation.</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the American Council on Aging Website, financial document review, medical record review, and interview, the facility failed in their responsibility in maintaining assets under \$2,000 for the 2026 Tennessee Medicaid allowance for 7 of 55 (Resident #12, #14, #30, #37, #50, #78, and #84) sampled residents. The findings include: 1. Review of the American Council on Aging Website, Tennessee Medicaid (TennCare) Income & Asset Limits for Nursing Homes & In-Home Long Term Care, dated 3/4/2026, revealed .In 2026, single Medicaid Nursing Home applicant in Tennessee must meet the following criteria.Assets under \$2,000. 2. Review of medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Hypertension, and Atrial Fibrillation. Review of the Resident Statement Landscape, dated 3/2/2026 revealed Resident #12's balance was \$10,975.19, which was \$8,975.19 over the \$2,000.00 limit. 3. Review of medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Anxiety, Alzheimer's, and Bipolar. Review of the Resident Statement Landscape, dated 3/13/2026 revealed Resident #14's balance was \$8,106.10, which was \$6,106.10 over the \$2,000.00 limit. 4. Review of medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Dementia, Epilepsy, and Depression. Review of the Resident Statement Landscape, dated 3/13/2026 revealed Resident #30's balance was \$2,808.26, which was \$808.26 over the \$2,000.00 limit. 5. Review of medical record revealed Resident #37 was admitted to the facility on [DATE], with diagnoses including Diabetes, Anemia, and Dementia. Review of the Resident Statement Landscape, dated 3/13/2026 revealed Resident #37's balance was \$2,542.12, which was \$542.12 over the \$2,000.00 limit. 6. Review of medical record revealed Resident #50 was admitted to the facility on [DATE], with diagnoses including Kidney Disease, Seizures, and Hypertension Review of the Resident Statement Landscape, dated 3/3/2026 revealed Resident #50's balance was \$5,639.36, which was \$3,639.36 over the \$2,000.00 limit. 7. Review of medical record revealed Resident #78 was admitted to the facility on [DATE], with diagnoses including Dementia, Osteoarthritis, and Chronic Pain. Review of the Resident Statement Landscape, dated 3/13/2026 revealed Resident #78's balance was \$3,348.96, which was \$1,348.96 over the \$2,000.00 limit. 8. Review of medical record revealed Resident #84 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes, and Anxiety Review of the Resident Statement Landscape, dated 3/13/2026 revealed Resident #84's balance was \$4,764.38, which was \$2,764.38 over the \$2,000.00 limit. During an interview on 3/25/2026 at 10:35 AM, with the Business Office Consultant (BOC), was asked can you tell me the limit a resident can have in their account. The BOC stated, \$2,000. During an interview on 3/25/2026 at 3:55 PM, with the Administrator, the Administrator was asked how much money is the maximum that should be in the resident trust. The Administrator stated . \$2,000 should be the max.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility's Situation Background Assessment Recommendation (SBAR) Note review, observation, and interview, the facility failed to notify the physician for 1 of 3 (Resident #81) sampled residents reviewed for falls. The findings include: 1. Review of the facility's policy titled, Change in a Resident's Condition or Status, dated 2/2021, revealed .Our facility notifies the resident, his or her attending physician.of changes in the resident's medical/mental condition and/or status.The nurse will notify the resident's attending physician or physician on call when there has been a (an).accident or incident involving the resident.significant change in the resident's physical/emotional/mental condition.need to alter the resident's treatment significantly.need to transfer the resident to a hospital/treatment center. 2. Review of the medical record revealed Resident #81 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Malnutrition, Hypertension, and Depression. Review of Physician's Order dated 10/9/2025, revealed Eliquis [used as a blood thinner].5 MG [milligram].Give 2 tablet by mouth two times a day. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #81 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was moderately cognitively impaired. Resident #81 was dependent on staff with activities of daily living (ADLs). Review of the facility's SBAR Note dated 3/14/2026, .Resident rolled over from her bed to the floor while she was being changed .Was the fall witnessed .Yes .Date and time of Fall: 3/14/2026 [at]10:30 AM .What was resident doing just prior to the fall .Resident was being changed in her bed .Vital Signs: BP [Blood Pressure]108/75, Pulse: 64 bpm [beats per minute] .Does the resident exhibit or complain of pain related to the fall .No .Location of injury: bruise to forehead, skin tear to left elbow .Note any injury to the head, extremities, or trunk .Swelling, Bump, Bruising .Alert Charting Notes .CNA [Certified Nursing Assistant] was changing resident when the resident rolled herself over the edge of the bed and onto the floor. CNA called nurse to bedside. Resident helped back to bed and assessed for injuries. Resident able to move all extremities as is her normal .Skin tear to left elbow and a bruised bump noted to forehead. Skin tear cleansed with normal saline. Xeroform and dry dressing applied. A second CNA was called to the room to prevent the resident from slipping over the edge of the bed while the resident was finished being changed. Review of the Nurse Practitioner (NP) Note dated 3/16/2026 at 7:51 PM, revealed Provider was not notified of patient fall that reportedly occurred on 3/14/2026 at the time of incident. Provider became aware of fall today 3/16/2026 upon review/discussion with nursing staff. On assessment today, patient noted to have left forehead hematoma and complaints of left hip pain. Patient is currently on Eliquis, increasing risk for bleeding complications. Given anticoagulation status and current findings, patient was sent to the emergency department for further evaluation and imaging. During an observation and interview in Resident #81's room on 3/23/2026 at 9:22 AM, Resident #81 was resting in bed with a hematoma (a swollen bruised area under the skin) to her forehead and a large bluish-yellow bruise in color from forehead to mid jawline to the left side of the resident's face, a gauze dressing to her left forearm with purple bruising noted under dressing. Resident #81 pointed to her left hip and complained of pain. Resident #81 was asked what happened. Resident #81 stated, had a fall a week ago Friday. During an interview on 3/24/2026 at 11:06 AM, Licensed Practical Nurse (LPN) B was asked about Resident #81's fall on 3/14/2026. LPN B stated [named CNA C] came to the entrance of the resident's room and waved me down.I entered the resident's room and saw the resident on her back on the floor with her head towards the head of the bed with her head tilted to the left side. LPN B was asked if the resident had any injuries. LPN B stated, She a skin tear to her left elbow that I went ahead and dressed and bruising to her face. LPN B was asked if she notified anyone. LPN B stated, I called her son. LPN B was asked if she notified the physician or NP. LPN B stated, No, I don't think (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>so. She [NP] was made aware a couple of days later. LPN B was asked if the physician or NP should have been notified considering the resident was taking Eliquis and hit her head. LPN B stated, I realize later the resident's fall should have been reported to the provider the same day. During an interview on 3/24/2026 at 2:05 PM, the NP was asked when she was made aware of Resident #81's fall on 3/14/2026. The NP stated, I was made aware when I was rounding at the facility on 3/16/2026 and I heard the resident calling out from her room. When I entered the resident's room I noticed a bruise to her face and hematoma to her forehead. I asked her nurse what happened and was told that the resident had a fall over the weekend. I went to ask the Director of Nursing [DON] if she was aware of the resident had fallen over the weekend. The NP was asked what she expects the facility staff to do when a resident has a fall. The NP stated, Report it to me or the on call especially if the resident is on Eliquis which is a concern. The resident could have a bleed and will need CT [Computed Tomography] and should be assessed for acute findings. The NP was asked would you expect staff to notify the provider the same day in this case. The NP stated, Yes, I do. During an interview on 3/24/2026 at 2:43 PM, the DON asked when she was made aware of Resident #81's fall on 3/14/2026. The DON stated, I was made aware the same day the NP was notified. She came and got me. The DON was asked what staff should do when a resident has a fall with injury. The DON stated, Call the provider and notify them of the fall.</p>		