STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445412	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Health Care Center	100 Cherrywood Place Jackson, TN 38305

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 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 policy review, medical record review, observation, and interview, the facility failed to maintain and ensure the prevention and spread of infection when staff failed to use Personal Protective Equipment (PPE) during dining and medication administration for 3 of 8 (Resident #7, #47, and #114) sampled residents reviewed. The findings include: 1. Review of the undated facility policy titled, Transmission-Based (Isolation) Precautions [TBP], revealed .Contact precautions.refer to measures.to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment.Droplet precautions.actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions.will don [put on] appropriate PPE before or upon entry into the environment of a resident on transmission-based precautions.Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment.Droplet Precautions.Healthcare personnel will wear a facemask for close contact with an infectious resident.Based upon the pathogen or clinical syndrome, if there is a risk of exposure of mucous membranes or substantial spraying of respiratory secretions is anticipated, gloves and gown as well as goggles (or face shield) should be worn. Review of the undated facility policy titled, Standard Precautions Infection Control Protocol, revealed Hand Hygiene .After touching blood, body fluids, secretions, excretions, contaminated items; before & after removing PPE; between resident contacts; before meals and after using the restroom .Gloves.For touching blood, body fluids, secretions, excretions, contaminated items.non-intact and intact resident skin .Gown.During procedures and resident-care activities when contact of clothing/exposed skin with bloody/body fluids, secretions, and excretions is anticipated . Review of the facility policy titled, Enhanced Barrier Precautions, dated March 20, 2024, revealed .Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms.Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .High-contact resident care activities include.Device care or use: central lines, urinary catheters, feeding tubes. 2. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses including Urinary Tract Infection, Extended Spectrum Beta Lactamase (ESBL) Resistance (Multidrug Resistance Infection), and Influenza. Review of the Physician Order dated 3/18/2026, revealed .Contact Isolation r/t [related to] ESBL IN URINE every shift.Droplet Precautions r/t: FLU [Influenza]. every shift. During an observation on 3/23/2026 at 11:58 AM, Certified Nursing Assistant (CNA) B entered Resident #7's room carrying a dining tray. Resident #7's door had 2 posted signs which declared Resident #7 was in Droplet and Contact Precautions. CNA B sat the dining tray on the over bed table and encouraged Resident #7 to wake up and eat. CNA B removed the cover of the lunch plate and placed the over bed table over Resident #7. CNA B left the room when the resident began to eat. CNA B failed to don PPE while in a Droplet/Contact Isolation room. During an observation on 3/23/2026 at 2:41 PM, Licensed Practical (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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse (LPN) A donned gloves, entered Resident #7's room, and detached the tubing of the completed antibiotic from the Peripherally Inserted Central Catheter (PICC) in the left arm of Resident #7. LPN A then went to the other side of the bed and turned Resident #7 onto her left side and straightened the bed covers before exiting the room. LPN A failed to don the appropriate PPE in an TBP room. During an interview on 3/25/2026 at 10:41AM, the Infection Control Preventionist (ICP) was asked what the protocol was when entering a resident's room that was in Transmission Based Precautions. The ICP stated, .will need to dress out with all PPE . gown, gloves, and mask.Yes.should dress out when delivering trays. The (ICP) was asked if staff should dress out when handling a PICC line or when turning a resident in the bed. The ICP stated, Yes.any close contact with a resident that is in isolation. 3. Review of the medical record revealed Resident #47 was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease, Dysphagia (difficulty swallowing), Diabetes, and Gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food.) Review of the quarterly MDS assessment dated [DATE], revealed Resident #47 scored a 6 on the BIMS assessment, which indicated she was severely cognitively impaired. Review of the of the Order Review History Report dated March 25, 2026 revealed orders for the following medications to be administered by G-Tube (Gastrostomy): Asprin (an anti-inflammatory medication) 81 mg (milligrams) daily Carvedilol (a blood pressure medication) 6.25 mg twice daily Folic Acid (a supplement) 1 mg every day Duloxetine (an antidepressant) 20 mg Delayed Release 2 capsules every day Jardiance (a medication to treat Diabetes) 10 mg every day Multivitamin liquid 5 ml (milliliters) every day Mirilax (a laxative)17 Grams every day Vitamin B-1 (a supplement) 100 mg every day Vitamin D-3 (a supplement)125 mcg every day Vitamin C (a supplement) 500 mg every day Vitamin E (a supplement) 400 units every day Zinc Citrate (a supplement) 50 mg every day Gabapentin (used to treat Neuropathy and Seizure Disorder) 300 mg two times a day Observation during medication administration on 3/25/2026 at 7:21AM, revealed LPN C prepared medications (meds) for administration through Resident #47's G-Tube. LPN C crushed the following meds and put them in a plastic cup: Aspirin, Folic Acid, Carvedilol, Duloxetine, Jardiance, Miralax, Vitamin B-1, Vitamin C, Vitamin D-3, Zinc, Gabapentin. LPN C put the liquid Multivitamins and Vitamin E in a second cup. LPN C entered Resident #47's room, without donning PPE, with both cups of meds and a third cup containing water, performed hand hygiene, donned gloves, checked placement of the G-tube, and checked for residual (measurement of remaining stomach contents.) LPN C flushed the G-Tube with 30 mls (milliliters) of water, administered the medications through the G-tube as ordered and flushed the G-Tube with another 30 mls of water. LPN C failed to wear PPE (gown) while administering medications in an EBP room. During an interview on 3/25/2026 at 7:45 AM, LPN C was asked if he should have worn a gown while in a room with EBP. LPN C stated .not with med administration just with care. During an interview on 3/25/2026 at 7:50 AM, the Director of Nursing (DON) was asked if a gown should be worn when administering medications through a Gastrostomy Tube. The DON stated, No, I don't think so, it's my understanding that only when providing care. Really, I don't know, I'm just going to be honest . 4. Review of the medical record revealed Resident #114 was admitted to the facility on [DATE], with diagnoses including Diabetes, Atrial Fibrillation, Anemia and Kidney Disease. Review of the quarterly MDS assessment dated [DATE], revealed Resident #114 scored a 11 on the BIMS assessment, which indicated he was moderately cognitively impaired. Review of Physician's Orders dated 3/11/2026, revealed .Repatha [a cholesterol lowering medication].140 MG/ML [MILLIGRAM/MILLILITER] Solution prefilled syringe. Inject 1ML Subcutaneously (SQ) to right low quadrant of the abdomen.every 2 weeks . Observation during medication administration on 3/25/2026 at 9:15 AM, revealed LPN D obtained a prefilled syringe of Repatha for administration to Resident #114. LPN D knocked on Resident #114's door, took the medication into the residents' room, explained the procedure, sanitized her hands, cleaned the right lower quadrant of Resident #114's abdomen with an alcohol prep and administered the Repatha injection subcutaneously. LPN D failed to don gloves before administering the injection to Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#114. During an interview on 3/25/2026 at 9:18 AM, LPN D was asked if she should have worn gloves while giving an injection. LPN D stated, .I guess, I thought somewhere along the way you didn't have to. During an interview on 3/25/2026 at 9:21 AM, the DON was asked if gloves should be worn when administering an injection. The DON stated, Yes ma'am .