STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445426	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shelby Oaks Post Acute	5070 Sanderlin Avenue Memphis, TN 38117

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review and interview, the facility failed to notify the provider and resident representative of a resident's change of condition and the failure to obtain stat labs and transfers for 1 of 4 (#76) sampled residents reviewed for notification of change. The findings include: 1. Review of the facility policy titled, Change in a Resident's Condition or Status, dated February 2021, revealed .Our facility notifies the resident, his or her attending physician and the resident representative of change in the resident's medical/mental condition .a nurse will notify the resident's representative.when.it is necessary to transfer the resident to a hospital/treatment center. 2. Review of the medical records revealed Resident #76 was admitted to the facility on [DATE] with diagnoses including Encephalopathy, Aphasia, Heart Failure, and Diabetes. Review of the quarterly MDS assessment dated [DATE], revealed Resident #76 was severely impaired for daily decision making. Review of the medical record revealed there was no documentation of Resident #76's transfer to the hospital or of the notification of the Responsible Party (RP) of the transfer on 5/9/2025. Review of the hospital admission H&P (History and Physical) dated 5/9/2025, revealed, .CHIEF COMPLAINT: Shortness of breath per facility.patient is nonverbal.presents to the hospital with acute hypoxic respiratory failure on workup patient was noted to have findings concerning for pneumonia versus volume overload/effusion. During an interview on 1/7/2026 at 4:44 PM, the Director of Nursing (DON) was asked should Resident #76's RP have been notified when he went to the hospital on 5/9/2025. The DON stated, Yes. The DON confirmed the facility was unable to provide that Resident #76's RP had been notified that he had been transferred to the hospital. The facility failed to notify the resident's RP of the transfer from the facility to the hospital.

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services for residents with enteral feedings for 2 of 2 (Resident #6 and Resident #54) sampled residents reviewed for Percutaneous Endoscopic Gastrostomy (a plastic tube inserted through the abdominal wall into the stomach) (PEG) tube feedings.The findings include: 1. Review of the facility policy titled, Enteral Nutrition, dated November 2018, revealed .Adequate nutritional support through enteral nutrition is provided to residents as ordered . 2. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Gastrostomy Status, Aphasia, Cerebral Infarction, and Dysphagia. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #6 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had intact cognition. Resident #6 received nutrition through a feeding tube. Review of the Physician Orders dated 11/26/2025, revealed .Vital Peptide 1.5.Liquid (Nutritional Supplements) Give 55 ml/hr [milliliters per hour] via [by] PEG-Tube every shift for feeding 55ml/hr continuously feeding 45ml auto [automatic] water flush. Observation in Resident #6's room on 1/5/2026 at 12:22 PM and at 4:15 PM, revealed an enteral feeding infusing with no infusion rate on the label and a water flush solution bag not labeled with a rate, date, or resident's name. 3. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE], with diagnoses including Gastrostomy Status, Dysphagia, and Abnormal Weight Loss. Review of the quarterly MDS dated [DATE], revealed Resident #54 scored a 00 on the BIMs assessment, which indicated the resident had severely impaired cognition. Resident #54 received nutrition through a feeding tube. Review of the Physician Orders dated 9/30/2025, revealed .every shift Enteral Feeding: glucerna [nutritional supplement] 1.5 @ [at] (50ml)cc/hr. H20 [water] 50ml/(22)hrs via (GT) [Gastrostomy Tubing]. Observation in Resident #54's room on 1/5/2026 at 12:34 PM and 4:35 PM, revealed Resident #54's enteral feeding being administered with no rate on the bottle and water flush solution bag not labeled with a with a rate, date, or resident's name. During an interview on 1/5/2026 4:38 PM, the Director of Nurses (DON) was asked about enteral feeding and labeling. The DON stated, .Staff should label feeding with a date and rate also on the water bottle with a date and rate. The DON was asked what about the name of resident. The DON stated, No we do not require a name on the enteral feeding or the water bottle but definitely the rate and date on the water bottle and feeding. Observation and Interview in Resident #54's room on 1/5/2026 at 4:39 PM, revealed the DON was to tell about the resident's enteral feeding and the water flush bag. The DON stated, There is no date on the enteral feeding bottle and there is no date, resident name, or rate on the water flush bag. Observation and interview in Resident #6's room on 1/5/2026 at 4:42 PM, revealed the DON observed the enteral feeding and the water flush bag and confirmed Resident #6's enteral feeding was hung and being administered with no infusion rate on the bottle and the water flush solution bag was hung and had no rate, date, or resident's name. During an interview on 1/7/2026 at 9:24 AM, Quality Service Registered Nurse [RN] E was asked if the facility had a policy and procedure for administering enteral feeding. Quality Service RN E stated, We use standard of practice for hanging administering enteral feeding.

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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 ensure practices to ensure the prevention and spread of infection were followed when 3 of 4 staff members (Certified Nurse Assistant (CNA) D and Licensed Practical Nurse (LPN) A, B and C) failed to wear proper personal protective equipment (PPE), failed to use a barrier during medication administration and failed to perform hand hygiene during incontinent care, wound care, medication administration and catheter (a thin flexible tube used to drain fluids from the body) care.The findings include: 1.Review of the facility policy titled, Handwashing/Hand Hygiene, dated August 2019, revealed This facility considers hand hygiene the primary means to prevent the spread of infections.use an alcohol-based hand rub.or alternatively, soap.and water for the following situations.before preparing or handling medications.after contact with a resident's intact skin.after handling used dressings, contaminated equipment.after removing gloves.hand hygiene is the final step after removing and disposing of personal protective equipment.the use of gloves does not replace hand washing/hand hygiene. Review of the facility policy titled, Enhanced Barrier Precaution, dated August 2022, revealed Enhanced barrier precautions (EBP's) are utilized to prevent the spread of multi-drug resistant organisms (MDRO's) to residents. Enhanced barrier precautions (EBP's) are used as an infection prevention and control intervention to reduce the spread of MDRO's to residents. EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: providing hygiene; changing linens; changing briefs or assisting with toileting; wound care (any skin opening requiring a dressing).EBP's are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.EBP's remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at risk. 2. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE], with diagnoses including Gastrostomy Status, Dysphagia, and Abnormal Weight Loss. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #54 score a 00 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had severely impaired cognition. Resident #54 had a sacral wound and a feeding tube. Review of the Order Review History Report dated 12/1/2025-12/31/2025 revealed .Enhanced Barrier Precautions during high contact time secondary to: (indwelling device, open wound) every shift for infection prevention . Review of the Order Review History Report dated 12/1/2025-12/31/2025 revealed Resident #54 had an order to clean her sacral wound with wound cleanser, pat dry, apply medicated gel, materials to promote tissue growth and absorb drainage and cover with a dry dressing every day. Observation in Resident #54's room on 1/5/2026 at 3:11 PM, revealed CNA D at the bedside wearing gloves, but failing to have on a gown, removed the covers, revealing the resident had a bowel movement and soiled the bandage to her sacral wound. CNA D removed a soiled pair of gloves, placed them in the trash and exited the room without performing hand hygiene. LPN C entered the room and donned gloves but failed to don a gown. CNA D returned to the room, without donning a gown, donned gloves and began performing incontinent care on Resident #54. LPN C, assisted in the incontinent care, removed the soiled dressing, cleaned the area surrounding the wound, rolled the soiled linen so that it could be removed, and performed wound care to the sacral area. After performing wound care, LPN C placed her gloves and soiled items in a red bag and washed her hands, donned new gloves and observed the bandage to Resident #54's Left foot. LPN C removed her gloves, without performing hand hygiene, donned new gloves and continued assisting CNA D in performing incontinent care. After completing the incontinent care, CNA D placed the soiled linen and soiled brief in a clear bag, removed his soiled gloves and placed them in the same clear bag, wrapped the soiled gloves around the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opening of the bag as a barrier, and exited the room, without performing hand hygiene, and took the clear bag out into the hallway. In the hallway, CNA D went to the dirty linen cart and obtained a second clear bag, and with ungloved hands, separated the soiled linen from the soiled brief and gloves and placed the soiled linen in the second clear bag. CNA D disposed of the bags and went into another resident's room to wash his hands. CNA D and LPN C failed to don the proper PPE during incontinent and wound care and failed to perform hand hygiene when donning and changing gloves. CNA D also handled soiled linen without PPE. During an interview on 1/05/2026 at 3:41 PM, LPN C was asked when a resident has a bowel movement and has a wound should staff wear a gown and gloves. LPN C stated, Yes, we should be wearing gown and gloves. 3. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses including Metabolic Encephalopathy, Dementia, Cognitive Communication Deficit, and Muscle Weakness. ˆ Review of the admission MDS dated [DATE], revealed Resident #77 scored a 5 on the BIMS assessment, which indicated the resident was severely cognitively impaired. Observation during medication administration on 1/7/2026 at 8:30 AM, revealed LPN A entered Resident #77's room and placed two eye drop containers and a cup containing oral medications on the over bed table without a barrier. LPN A then donned gloves, administered the first eye drops, removed her gloves, and failed to perform hand hygiene before donning another pair of gloves. LPN A administered the second eyedrops, removed her gloves, and failed to perform hand hygiene before donning a new pair of gloves. LPN A placed a medicated patch on Resident #77's right ankle, removed her gloves, and failed to perform hand hygiene before donning a new pair of gloves, then administered oral medications to Resident #77. LPN A failed to use a barrier between the resident's medications and the over the bed table and failed to perform hand hygiene when donning and changing gloves during medication administration. 4. Review of the medical record revealed Resident #75 was admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection and Presence of Urogenital Implants. Review of the admission MDS assessment dated [DATE], revealed Resident #75 scored a 12 on the BIMS assessment, which indicated the resident had moderately impaired cognition. Review of the Order Summary Report dated 1/7/206, revealed .Urostomy/Nephrostomy: Change .bag 30 days and PRN [as needed] . Review of the Order Summary Report dated 1/7/2026 revealed Resident had an order for EBP every shift related to indwelling device (Urostomy tube). Observation in Resident #75's room on 1/5/2026 at 12:40 PM, revealed LPN B, without wearing a gown, placed a cover over the urine filled catheter bag with gloved hands. LPN B placed the catheter bag between the resident and the wheelchair, removed her gloves, picked up and placed a lid over Resident #75's food tray and walked out of the room. LPN B failed to have on proper PPE while handling the urine filled catheter bag and failed to perform hand hygiene after she removed her gloves. During an interview on 1/8/2026 at 8:50 AM, the DON was asked what should staff wear when a resident is on Enhance Barrier Precautions. The DON stated, Wear gloves and isolation gown for sure . During an interview on 1/8/2026 at 10:40 AM, the Director of Nursing (DON) was asked when staff should wash their hands during medication administration. The DON stated .They should always wash their hands in between glove changes . ˆ The DON acknowledged nurses should use barriers on tables in resident's rooms during medication administration.