STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445443	A. Building B. Wing	02/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Healthcare and Rehabilitation Center	1245 E College St Pulaski, TN 38478

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, record review, and facility policy review, the facility failed to complete an assessment for self-administration of medications for 1 (Resident #38) of 5 residents reviewed for medication administration. Findings included: A facility policy titled, Self-Administration of Medication, revised 01/01/2025, indicated, If the resident indicates a desire to self-administer medication, he/she shall be assessed utilizing the Self-Administration of medication assessment found under the assessment tab in the EHR [electronic health record]. A Face Sheet revealed the facility admitted Resident #38 on 07/07/2022. According to the Face Sheet, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, urticaria (hives), dementia, and allergic rhinitis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2025, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS revealed Resident #38 was able to make themself understood and able to understand others. Resident #38's Care Plan Report, revealed a focus area revised on 03/22/2025, that indicated the resident had the potential for impaired cognitive function or impaired thought processes related to dementia. Interventions initiated 03/22/2025 included administering medications as ordered, discussing concern about confusion and disease process with family, and giving step-by-step instructions one at a time as needed to support cognitive function. An observation on 02/17/2026 at 10:41 AM in Resident #38's room revealed a tube of Aspercreme pain relief cream, Orajel cream, Afrin nasal spray, and hydrocortisone cream on the resident's overbed table. An observation on 02/18/2026 at 9:10 AM revealed hydrocortisone cream was on Resident #38's overbed table. During a concurrent interview, Resident #38 stated that staff had put the other medications in their dresser drawer. An observation revealed the Aspercreme, Orajel cream, and Afrin nasal spray in the top drawer of the resident's dresser. Resident #38 stated that staff had told them they were not allowed to keep the medications on their overbed table and the medication needed to be kept in the dresser drawer. Resident #38 stated they took the Afrin nasal spray every night. During an interview on 02/18/2026 at 9:17 AM, Licensed Practical Nurse (LPN) #1 stated all resident medications, including over-the-counter medications, were kept on the medication cart. LPN #1 stated that to her knowledge, residents in long-term care facilities were not allowed to keep medications, including over-the-counter medications, in their rooms. When LPN #1 was shown the medications in Resident #38's room, she stated the medications should not be in the room, and she had removed the medications from Resident #38's room in the past. LPN #1 removed the medication from the room. During a concurrent interview, Resident #38 stated they did not know why they could not keep their stuff. Resident #38's Order Summary Report, with active orders as of 02/18/2026, revealed no active orders for Aspercreme, Orajel, Afrin nasal spray, or hydrocortisone cream. The Order Summary Report also revealed no active orders for the resident to self-administer medication. A review of Resident #38's EHR revealed no assessment for self-administration of medication. During an interview on 02/19/2026 at 11:45 AM, the Director of Nursing (DON) stated the facility had no residents who self-administered medications. The DON stated if a resident wanted to self-administer medications, they would complete an assessment, provide a lock box to store the medications, and get an order from the physician. The DON denied prior knowledge of Resident #38 (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requesting to self-administer medications, but acknowledged she was now aware that the resident had been self-administering medications. The DON stated that Resident #38 had never had an assessment to self-administer medications. During an interview on 02/19/2026 at 12:05 PM, the Administrator (ADM) stated that as far as she was aware, the facility had no residents who self-administered their medications. The ADM stated she was unaware Resident #38 requested to self-administer medications or requested to keep medications in their room. The ADM stated there should be no medications in Resident #38's room if they had not gone through the proper procedures for self-administration.

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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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure enhanced barrier precautions (EBP) were implemented for 1 (Resident #9) of 25 residents reviewed for EBP. Findings included: A facility policy titled, Transmission Based Precautions, revised 01/01/2025, indicated, It is our policy to take appropriate precautions to prevent transmission of infectious agents. ?Enhanced barrier precautions' (EBP) refers 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. Initiation of Enhanced Barrier Precautions: 2. An order for enhanced barrier precautions shall be obtained for residents with any of the following: i. Wounds (e.g. [exempli gratia, for example], chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO [multidrug-resistant organism]. ii. Infection or colonization with a CDC [Centers for Disease Control and Prevention]-targeted MDRO when Contact Precautions do not otherwise apply. Implementation of Enhanced Barrier Precautions: 1. Make gowns and gloves available which may include near or outside of the outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e. [id est, that is], wound irrigation, tracheostomy care). 2. PPE [personal protective equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. An admission Record revealed the facility admitted Resident #9 on 01/13/2026. According to the admission Record, the resident had a medical history that included a diagnosis of gastrostomy status. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/20/2026, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate impairment in cognition. The MDS revealed the resident had a feeding tube and one Stage 2 pressure ulcer. Resident #9's Order Summary Report, with active orders as of 02/19/2026, revealed an order dated 02/18/2026 for EBP. The indications listed were wounds and percutaneous endoscopic gastrostomy (PEG) tube. On 02/18/2026 at 9:50 AM, two staff members were observed going into Resident #9's room. The staff were observed entering the room with clean bedding and supplies to give the resident a bed bath. During an observation on 02/18/2026 at 10:00 AM, two staff members were observed finishing up with a bed bath for Resident #9. The staff members were observed pulling the covers up over the resident and positioning the resident up in bed. One staff member was observed leaning and reaching over the resident, allowing her clothing to touch the bedding. The staff member placed a pillow under the resident's head. The two staff members who were providing close contact care were observed wearing gloves. The two staff members did not have a gown on. There was an EBP sign in the middle of the resident's door indicating staff should wear gowns and gloves during close contact care. On 02/18/2026 at 10:01 AM, Certified Nursing Assistant (CNA) #9 stated she provided care for Resident #9 and provided the bed bath. She stated the PPE used to give Resident #9 a bath was gloves. CNA #9 observed the door and stated the resident was on EBP, and she should have worn a gown. She stated that the resident had a wound. On 02/18/2026 at 10:31 AM, CNA #10 stated she provided the bed bath for Resident #9. She stated she was wearing gloves to provide the bed bath. She stated she should have also been wearing a gown. She stated the resident was on EBP, and the directions were on the door. She stated that if she had close contact with the resident, a gown and gloves should have been worn. She stated she just realized she had not worn the proper PPE. She stated she should have been wearing a gown due to the resident being on EBP. On 02/19/2026 at 9:19 AM, the Assistant Director of Nursing (ADON), who is also the Infection Preventionist (IP), stated residents requiring EBP have signs on their door and in their room. He stated that EBP should be initiated for residents with wounds that required dressing changes and catheters. He stated he would expect staff to wear a gown and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves when providing a bed bath to a resident with a PEG tube and a wound. On 02/19/2026 at 10:01 AM, the Director of Nursing (DON) stated that for a resident requiring EBP, staff should wear gloves and a gown with any close contact. She stated she would expect the staff to wear gloves and a gown while providing a bed bath. She stated Resident #9 required EBP, and she expected staff to wear a gown and gloves. On 02/19/2026 at 2:09 PM, the Administrator stated she expected a gown and gloves to be worn if that was what the EBP guidelines required.