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	09/30/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, Emergency Medical Services (EMS) run report review, hospital record review, Medicolegal Death Investigator email, and interview, the facility failed to protect the residents' right to be free from abuse for 2 of 9 (Resident #1 and Resident #13) sampled residents reviewed for abuse. On 8/21/2025, the medical record of Resident #1, a vulnerable and cognitively impaired resident, revealed a skin assessment that documented a knot (raised area) to the left and right side of Resident's #1's forehead. On 8/28/2025, the medical record revealed Resident #1's right hand was swollen, warm to the touch, and painful. On 8/29/2025, the medical record documented an opened reddened area to the left side of Resident's #1's abdomen and an abrasion to the Resident's neck, which was documented as a large area of injury from the front of the neck to the back of the neck. On 9/8/2025 at 5:08 AM, Resident #1 was transferred to a local hospital for difficulty breathing, diminished irregular lung sounds and elevated blood pressure, with critical vital signs. The Resident was unable to respond to the nurse. Review of the hospital documentation dated 9/8/2025, revealed an Acute Ischemic Stroke (when a blood clot blocks an artery in the brain cutting off blood flow), Acute Hemorrhagic Stroke (when a blood vessel in or near the brain ruptures, causing bleeding in the brain), Basilar Skull Fracture (a break in one of the bones at the base of the skull), Cervical Spine Injury (spinal cord in the neck is damaged), Epidural Hematoma (blood accumulates in the skull), Hemothorax (blood accumulates between the lung and the chest wall) , Hemorrhage Shock (blood loss to the body's organs), Hollow Viscus Injury (a tear in the wall of a hollow organ in the gastrointestinal tract), Multiple Rib Fracture, Pneumothorax (air leaks into the space between the lungs and chest wall), Spinal Cord Injury, Splenic Laceration (injury/trauma of the spleen), Subarachnoid Hemorrhage (bleeding between the brain and the tissue covering the brain), Subdural Hematoma (a pool of blood between the brain and it's outermost covering). Facility staff failed to assess Resident #1's injuries and facility staff failed to document or investigate how each of the injuries occurred. Medicolegal Death Investigator email provided to the facility revealed Resident #1's time of death was 9/12/2025 at 4:32 AM. The facility failed to provide documentation of an occurrence report for each of Resident #1's injuries. The facility failed to document the Resident's falls. The facility staff failed to report and investigate injuries of unknown origin. Review of the medical record dated 12/27/2024, revealed Resident #13, who was a vulnerable, cognitively impaired resident, had red scratches on his face, a knot and bruising to the right side of his head, and a swollen left hand which resulted in a 5th proximal phalanx (finger bone) fracture. Nursing staff failed to assess Resident #13's injuries and failed to document and investigate how each of the injuries occurred. The facility failed to provide documentation of an assessment, or an occurrence report for Resident #13's injuries. The facility failed to notify the Physician at the time of occurrence. The facility failed to report and investigate injuries of unknown origin. Resident #13 no longer resides in the facility. The facility should ensure residents residing in the facility receive the needed services to prevent neglect, such as injuries of unknown origin, which can cause serious harm, impairment, or death. Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to identify, assess, investigate, and report injuries of unknown origin related to Resident #1's and 13's injuries of unknown, placed all residents at risk. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) for F-600 on 9/23/2025 at 4:01 PM, in the Conference Room. An amended template was presented the Administrator on 9/24/2025 at 4:12 PM. The facility was cited IJ at F-600 at a scope and severity of J, which is substandard quality of care. The Immediate Jeopardy for F-600 began on 8/21/2025 and was removed on 9/25/2025. A partial extended survey was conducted from 9/25/2025 - 9/29/2025. An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F-600 was received on 9/25/2025. The Removal Plan was validated on-site by the surveyor on 9/30/2025 by medical record review, monitoring log review, education record review, and staff interviews. The facility's noncompliance at F-600 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a plan of correction. The findings include: 1. Review of the facility policy titled, Identifying Types of Abuse, dated 9/2022, revealed .As part of the abuse prevention strategy.employees.are expected to be able to identify the different types of abuse that may occur against residents.Abuse of any kind against residents is strictly prohibited.Abuse prevention includes

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to ensure injuries of unknown origin were reported immediately, but not later than 2 hours, after the allegation was made for 2 of 9 (Resident #1 and Resident #13) sampled residents reviewed for abuse. The findings include: 1. Review of the facility's policy Abuse Investigation and Reporting dated10/2022, revealed .All reports of resident abuse, neglect.and/or mistreatment (abuse)shall be promptly reported to local, state and federal agencies (as defined by current regulations).Findings of abuse investigations will also be reported. Reporting.All alleged violations involving abuse, neglect, exploitation, or mistreatment, and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies:.The State licensing/certification agency responsible for surveying/licensing the facility;.The local/State Ombudsman;.The Resident Representative (Sponsor) of record;.Law enforcement officials; The resident's Attending Physician.An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than:.Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or.Twenty-four (24) hours if the alleged violation does not involve abuse OR has not resulted in serious bodily injury.Verbal/written notices to agencies may be submitted via special carrier, fax, e-mail, or by telephone.Notices will include.The name of the resident.The number of the room in which the resident resides.The type of abuse that was committed.The date and time the alleged incident occurred.The name(s) of all persons involved in the alleged incident.and.What immediate action was taken by the facility.The Administrator (or designee) will provide the appropriate agencies or individuals.with a written report of the findings of the investigation within (5) working days of the occurrence of the incident. Appropriate professional and licensing boards will be notified when an employee is found to have committed abuse. Review of the facility's STATEMENT OF IN-SERVICE TRAINING FOR EMPLOYEES dated 9/18/2025, revealed .The following areas of instruction were covered: Event Note/Incident Process (Falls, Abuse, Misappropriation, Behaviors, Elopement, Injuries, new skin issues (abrasions, bruises, lacerations.) Review of the facility's undated policy Falls and Fall Risk, Managing revealed .a fall is defined as. Unintentionally coming to rest on the ground, floor or other lower level, but not as an overwhelming external force.An episode where a resident lost his/her balance and would have fallen.is considered a fall.when a resident is found on the floor, a fall is considered to have occurred. Review of the facility's policy Occurrence Reporting dated 12/1/2023, revealed .The facility may complete a Nurse Event note to document the details of an accident/incident/occurrence/unusual event affecting the resident.Completion of the Nurse Event note is critical to the investigation process.Definitions. A Nurse Event Note is an assessment that is completed to record the details of accidents/incidents, patient injury and other unusual events/occurrences that occur while a patient resides in a health care facility.The following are examples accidents/incidents are events/occurrences that require the completion of a Nurse event note.Violence or aggression (patient to patient altercation).Falls.Bruises.Abrasions.Skin tears.Fracture.All observed, reported, or other acquired knowledge of an occurrence must be reported to the charge nurse or DON [Director of Nursing] by the employee who finds or witnesses the incident. 2. Review of the medical record revealed Resident #1 was admitted on [DATE] with readmission on [DATE], with diagnoses including Paranoid Schizophrenia, Alzheimer's Disease, and Hypertension. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #1's Brief Interview for Mental Status (BIMS) was 9, indicating Resident #1 was moderately cognitively impaired and had poor short term and long-term memory. Resident #1 required substantial/maximal assistance with toileting, shower/bathing, dressing, and bed mobility. Review of the medical record dated 8/21/2025, revealed Resident #1 sustained an injury of unknown origin, a knot (raised area) to the left and right side of his head. The facility failed to complete an occurrence report, a head-to-toe assessment, or document of how the injury occurred. The facility failed to document a detailed description of the injury of unknown origin in the medical record. Review of the medical record dated 8/28/2025, revealed Resident #1 sustained an injury of a painful swollen right hand. The facility failed to complete an occurrence report, a head-to-toe assessment, or document of how the injury occurred. The facility failed to document a detailed description of the injury of unknown origin in the medical record. Review of the medical record dated 8/29/2025, revealed Resident #1 sustained an injury of a large bruise from stretching from one side of his neck to the other and an open area to his abdomen. The facility failed to complete an occurrence report, a