

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/11/2025
NAME OF PROVIDER OR SUPPLIER  Majestic Gardens at Memphis Rehab & Snc		STREET ADDRESS, CITY, STATE, ZIP CODE  131 N Tucker Memphis, TN 38104	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>(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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, record review, observations, and interviews, the facility failed to ensure residents were free from physical restraints for 1 of 1 (Resident #14) sampled residents reviewed for physical restraints. The findings include: Review of the undated facility policy titled, Use of Restraints, revealed .Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented.Physical Restraints. are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.If the resident cannot remove a device in the same manner in which the staff applied it.and this restricts his/her typical ability to change position or place, that device is considered a restraint.Examples of devices that are/may be considered physical restraints include.trays that the resident cannot remove.Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints.Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s).Documentation regarding the use of restraints shall include.full documentation of the episode leading to the use of the physical restraint.a description of the resident's medical symptoms.that warranted the use of restraints.how the restraint use benefits the resident by addressing the medical symptom.the type of restraint used.the length of effectiveness of the restraint time.observation, range of motion and repositioning flow sheets. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Dementia, Psychotic Disorder with Delusions, Pseudobulbar Affect, Depression, and Insomnia. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #14 was severely cognitively impaired. Resident #14 was not coded for the use of restraints. Review of the Physician's Orders revealed there was no order for a Geri chair (used to provide comfortable seating for individuals with limited mobility or who have difficulty sitting upright in a wheelchair) or tray. Review of the Care Plan dated 8/4/2025, revealed no interventions that included the use of a Geri chair or tray. Review of the medical record revealed no documentation of a restraint assessment, no documentation of resident representative consent, and no documentation of Geri chair or tray use. Observation at the Secure Unit's nurses' station on 9/8/2025 at 10:24 AM and 11:40 AM, revealed Resident #14 sitting in a Geri chair with a tray. There was no food or any type of activity on the tray. Observation in the Resident's room on 9/10/2025 at 8:04 AM, revealed Resident #14 was sitting in a Geri chair with a tray in place. There was no food or any type of activity on the tray. During an interview on 9/10/2025 at 11:34 AM, the Certified Nursing Assistant (CNA) I was asked how often the tray was connected to Resident #14's Geri chair. CNA I stated, .most of the time. During an interview on 9/10/2025 at 11:36 AM, Licensed Practical Nurse (LPN) J was asked how long Resident #14 had been using a tray on the Geri chair. LPN J stated, .the last couple of weeks.that's how long I've been working this hall. LPN J confirmed that Resident #14 could not remove the tray if asked. During an interview on 9/11/2025 at 9:12 AM, the MDS Coordinator was asked what the process for restraints was. The MDS Coordinator stated, We are a restraint free facility. The MDS coordinator confirmed that a restraint is something that restricts movement and cannot be removed by the resident, and the use of a tray on a Geri chair should be documented in the resident's care plan. During an interview on 9/11/2025 at 12:57 PM, the Director of Nursing confirmed that a Geri chair with tray would be considered a restraint if the resident is unable to remove the tray, and that use of a Geri chair with a tray should be documented in the medical record.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, medical record review, and interview, the facility failed to ensure staff reported an allegation of staff to resident abuse to the appropriate agencies in a timely manner for 2 of 3 (Resident #65 and #107) sampled residents for allegations of abuse. The findings included: 1. Review of the facility policy titled, Facility Responsibility for Reporting Allegations, dated September 2022, revealed .All allegations/occurrences of all types of staff-to-resident abuse must be reported to the administrator and to other officials, including the State Survey Agency and adult protective services. 2. Review of medical records revealed Resident #65 was admitted on [DATE], with diagnoses including Cerebral infarction, Chronic Kidney Disease, and Diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #65 was cognitively intact. Review of the facility investigation dated 8/29/2025, revealed Resident #65 reported an allegation of sexual abuse by CNA C on 8/29/2025. Resident #65 stated while providing care CNA C took his hand and placed it on her stomach, side of her hip and on her behind. Resident #65 stated CNA C walked out of the room and didn't say anything. CNA C was suspended pending investigation. The facility notified the Police, Long Term Care, Ombudsman, Adult Protective Services, and Resident #65's family. There was no documentation the State Survey Agency was notified of the allegation of abuse in a timely manner. During an interview on 9/10/2025 at 1:55 PM, the Administrator confirmed that the incident occurred on 7/10/2025 and the staff failed to report the allegation of abuse to the Director of Nursing or the Administrator until 8/29/2025. The Administrator confirmed that she should have been notified immediately. During an interview on 9/11/2025 at 1:05 PM, the DON confirmed that allegations of abuse should be reported within 2 hours of the allegation. 3. Review of the medical record revealed Resident #107 was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, and Peripheral Vascular Disease. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated that Resident #107 was cognitively intact. Review of the facility investigation report dated 9/9/2025, revealed the Administrator spoke with Resident #107 regarding the allegation of staff to resident abuse. Resident #107 alleged that CNA F came in his room, and he asked her to shave him. Resident #107 stated that CNA F told him to say Please, and he told her that he didn't think he had to beg. The administrator contacted Resident #107's daughter and searched and found that CNA F matched the description Resident #107 provided. CNA F was terminated on 8/27/2025. During an interview on 9/11/2025 at 1:05 PM, The DON confirmed that allegations of abuse should be reported within 2 hours of the allegation. The incident was reported to the Administrator on 9/9/2025 at 12:03 PM and was not reported until 9/11/2025. The facility failed to report an allegation of abuse in a timely manner.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(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 - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, medical record review, and interview, the facility failed to ensure Activities of Daily Living (ADL) assistance was provided related to showering and personal hygiene care for 4 of 5 (Resident #2, #3, #89 and #148) sampled residents reviewed for ADLs. The findings include: 1. Review of the undated facility policy titled, Activities of Daily Living (ADLs), Supporting, revealed .Residents will be provided with care to carry out activities of daily living independently will receive the services necessary to maintain good .grooming and personal and oral hygiene .Appropriate care and services will be provided for the residents who are unable to carry out ADLs independently .including assistance with .hygiene (bathing, dressing, grooming and oral care) . 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Hemiparesis and Morbid Obesity. Review of the significant change Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #2 was cognitively intact. Resident #2 required maximum assistance from the staff for personal hygiene. Review of the Care Plan dated 7/2/2025, revealed Resident #2 had an ADL Self Care deficit and required staff assistance with ADLs. Review of the undated Shower Schedule revealed Resident #2 was to get a shower on Tuesday and Friday on the 7:00 AM-3:00 PM shift. During an observation and interview on 9/8/2025 at 10:57 AM, Resident #2 stated she had not had a shower for at least a week. The resident's hair appeared oily and was uncombed. During an interview on 9/10/2025 at 2:29 PM, Certified Nursing Assistant (CNA) L stated that the electronic medical record (EMR) would show whether a resident had received a shower or a bath and what days it was given. CNA L opened up the EMR to reveal there was no documentation for a shower or bath on the EMR from 8/29/2025 until 9/10/2025. During an interview on 9/11/2025 at 12:58 PM, the Director of Nursing (DON) confirmed it was not acceptable for a resident who was dependent on staff for ADL care to go 10 days without a shower. 3. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses including Diabetes, Psychotic Disorder with Delusions, Protein Calorie Malnutrition, and Dementia. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 3 which indicated Resident #3 was severely cognitively impaired. Review of the care plan dated 5/10/2025, revealed Resident #3 required substantial assistance from the staff for personal hygiene. Observation in Resident #3's room on 9/9/2025 at 8:36 AM, revealed that Resident #3's toenails were tan in color and extended about 1/2 inch from the end of the toe. During an observation and interview in Resident #3's room on 9/9/2025 at 2:43 PM, revealed the DON was shown Resident #3's toenails, and she confirmed they were long and needed to be cut. 4. Review of the medical record revealed Resident #89 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Dementia, Diabetes, Anxiety, and Malignant Neoplasm of the Colon. Review of the care plan dated 3/2/2025, revealed Resident #89 had an ADL Self Care Performance Deficit related to (r/t) decreased mobility/Dementia. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 4, which indicated Resident #89 was severely cognitively impaired. Resident #89 required moderate to maximal assistance from staff with ADLs. Review of the care plan for Resident #89 with a revision date of 9/9/2025, revealed .BATHING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse . During an observation in Resident #89's room on 9/10/2025 at 7:43 AM, Family Member N was in the room and had removed Resident #89's socks. Resident #89's toenails were thick, long, and curling upward. The family member stated .they [toenails] need to be cut . During an observation and interview in Resident #89's room on 9/10/2025 at 7:57 AM, the DON was shown the Resident's toenails. The DON confirmed the nails were extremely long and needed to be cut. 4. Review of the medical record revealed Resident #148 was admitted to the facility on [DATE], with diagnoses including Osteomyelitis, Spinal Stenosis, Chronic Obstructive Pulmonary Disease, and Anxiety. Review of the care plan for Resident #148 dated 9/4/2025, revealed . has an ADL Self Care Performance Deficit .BATHING: I require substantial/maximal staff participation with bathing . Review of the undated Shower Schedule revealed Resident #148 was to get a shower on Monday and Thursday on the 3:00 PM-11:00 PM shift. The facility was unable to provide shower sheets for Resident #148. Review of the .Skilled Nursing Center Documentation Survey Report . dated September 2025, revealed no documentation Resident #148 received a shower since admission on [DATE]. During an interview on 9/9/2025 at 9:17 AM, Resident #148 stated she had not had a shower since 9/4/2025. During an interview on 9/10/2025 at 10:10 AM, Unit Manager K was</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, medical record review, and interview, the facility failed to ensure staff were dispensing and accurately administering medications and treatments per Physician's Orders for 4 of 32 (Residents #3 #41, #51, and #148) residents reviewed. The findings include: 1. Review of the facility policy titled, Medication Administration, dated 7/2023, revealed .Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medications. Medications are administered in accordance with written orders of the attending physician. The resident's MAR/EHR [Medication Administration Record/Electronic Health Record] is initiated by the person administering the medication, in the space provided under the date and on the line for that specific medication dose administration time. 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Diabetes, Psychotic Disorder with Delusions, Protein Calorie Malnutrition, and Dementia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7 which indicated Resident #3 was severely cognitively impaired. Review of the Physician's Orders dated June 2025, revealed .amLoODIPine [amlodipine] Besylate [used for high blood pressure] .Hold for systolic &lt; [less than] 120 . Review of the MAR dated June 2025, revealed Amlodipine was administered when the blood pressure was outside the parameters on the following dates: a. 6/3/2025 with a blood pressure (BP) of 113/63. b. 6/10/2025 with a BP of 109/93. c. 6/11/2025 with a BP of 112/84. d. 6/12/2025 with a BP of 104/68. e. 6/13/2025 with a BP of 118/72. f. 6/19/2025 with a BP of 107/61. g. 6/20/2025 with a BP of 110/68. h. 6/21/2025 with a BP of 114/72. i. 6/23/2025 with a BP of 116/76. j. 6/26/2025 with a BP of 119/69. k. 6/27/2025 with a BP of 106/64. l. 6/28/2025 with a BP of 104/60. Review of the Physician orders dated July 2025, revealed .amLoODIPine [amlodipine] Besylate [for high blood pressure] .Hold for systolic &lt; [less than] 120 . Review of the MAR dated July 2025, revealed Amlodipine was administered when the blood pressure was outside the parameters on the following dates: a. 7/6/2025 with a BP of 112/81. b. 7/9/2025 with a BP of 110/60 c. 7/11/2025 with a BP of 110/60. d. 7/14/2025 with a BP of 104/65. e. 7/15/2025 with a BP of 111/68. f. 7/28/2025 with a BP of 118/60. g. 7/29/2025 with a BP of 108/51. Review of the MAR dated August 2025, revealed Amlodipine was administered when the blood pressure was outside the parameters on the following dates: a. 8/3/2025 with a BP of 112/56. b. 8/4/2025 with a BP of 118/66. c. 8/18/2025 with a BP of 116/65. d. 8/21/2025 with a BP of 117/64. During an interview on 9/11/2025 12:49 PM, the Director of Nursing (DON) confirmed that the medication was administered outside of the parameters and should have been held. 3. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Chronic Kidney Disease, Encephalopathy, and Hypertension. Review of the Physician's Orders dated 4/21/2025, revealed .Triple Antibiotic External Ointment [(TAO) used for wound healing] .Apply to Rt [Right] eyebrow topically every day shift every other day for wound healing Cleanse skin tear with wound cleanser and apply TAO and a bandage every other day until healed. Review of the Treatment Administration Record (TAR) dated 4/2025, revealed no documentation for 4/23/2025, 4/25/2025, and 4/27/2025 for treatment to the skin tear to the right eyebrow. Review of the TAR dated 5/2025, revealed no documentation for 5/11/2025, 5/13/2025, 5/15/2025, and 5/19/2025 for treatment to the skin tear to the right eyebrow. There was no documentation of treatment to Resident #41's right eyebrow for 7 of 15 treatment dates. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) was unable to be completed, which indicated Resident #41 was severely cognitively impaired. During an interview on 9/11/2025 at 12:57 PM, the Director of Nursing (DON) confirmed if a medication or treatment was not documented as completed then it was not done. 4. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Muscle Wasting and Atrophy, Arthritis, and Depression. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 13 which indicated Resident #51 was cognitively intact. Review of the Physician's Orders dated 9/7/2025, revealed .cefTRIAXone Sodium [antibiotic] Intravenous Solution .Use 1 gram intravenously one time a day for UTI [Urinary Tract Infection] for 7 Days . Review of the care plan revised on 9/8/2025, revealed .The resident [Resident #51] is on Antibiotic Therapy r/t [related to] infection (/ITI) [Urinary Tract Infection] Administer medication as ordered . Review of the MAR dated September</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, medical record review, observation, and interview, the facility failed to store medication in accordance with facility policy when medication was found unsecured at the bedside for 4 of 32 (Resident #11, # 72, #122, and #148) residents. The findings include: 1. Review of the facility policy titled, Medication Storage, dated 4/2025, revealed .The facility is responsible for maintaining proper storage.All medication will be stored according to state and federal laws and regulations.Oral (solid) medication-stored in medication carts except those requiring refrigeration.All medication with routes other than PO (oral) must be stored in separate compartments in medication cart, medication room cabinets, or refrigerator. 2. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Arthritis, Chronic Pancreatitis, Anemia, and Hypertension. Review of the quarterly Minimal Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #11 was cognitively intact. Observation in Resident #11's room on 9/8/2025 at 9:52 AM and 10:50 AM, revealed a 0.5 milliliter (ml) bottle of earwax removal aid was observed at bedside. During an observation and interview on 9/8/2025 at 11:47 AM, Licensed Practical Nurse (LPN) E confirmed that the bottle of earwax removal aid should not be at Resident #11's bedside. 2. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE], with diagnoses including Diabetes, Anemia, Epilepsy, and Hypertension. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 13, which indicated Resident #72 was cognitively intact. Observation in Resident #72's room on 9/8/2025 at 9:42 AM and 11:20 AM, revealed an approximately one-half full roll of (Named) over the counter antacid wrapped in foil observed at the bedside. During an observation and interview on 9/8/2025 at 11:42 AM, LPN E confirmed the (Named) over the counter antacid should not be at Resident #72's bedside. 3. Review of the medical record revealed Resident #122 was admitted to the facility on [DATE], with diagnoses including Protein Calorie Malnutrition, Diabetes, Pressure Ulcer, and Encephalopathy. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 13 which indicated Resident #122 was cognitively intact. Observation in Resident #122's room on 9/10/2025 at 7:50 AM, revealed a bottle of wound cleanser and tube of moisture barrier ointment were observed on the nightstand. During an observation and interview on 9/10/2025 at 7:52 AM, the Director of Nursing (DON) confirmed the wound cleanser and barrier ointment should not be left in Resident #122's room. 4. Review of the medical record revealed Resident #149 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarct (condition where blood flow to the brain is interrupted), Vascular Dementia, and Depression. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 6, which indicated Resident #149 was severely cognitively impaired. Observation in Resident # 149's room on 9/8/2025 at 10:22 AM and 2:52 PM, revealed a tube of antifungal ointment at the bedside. During an interview on 9/8/2025 at 2:53 PM, LPN G confirmed antifungal ointment should not be at Resident #149's bedside. During an interview on 9/11/2025 at 12:57 PM, the DON confirmed that medications including over the counter medications and/or topical ointments should not be left at a Resident's bedside unattended.</p>		

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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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when 1 of 4 nurses (Licensed Practical Nurse (LPN) A) failed to disinfect reusable resident equipment for 1 of 5 (Resident #151) residents observed during medication administration. The findings include: Review of the undated facility policy titled, Cleaning and Disinfection of Resident -Care Items and Equipment, revealed .Resident-care equipment, including reusable items.will be cleaned and disinfected.Reusable items are cleaned and disinfected or sterilized between residents.Reusable resident care equipment is decontaminated and/or sterilized between residents. Review of medical record revealed Resident #151 was admitted to the facility on [DATE], with diagnoses including Dementia, Hypertension, and Schizophrenia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated Resident #151 was moderately cognitively impaired. Observation in Resident #151's room on 9/9/2025 at 4:16 PM, revealed Licensed Practical Nurse (LPN) A obtained Resident #151's blood pressure with an automatic wrist blood pressure monitor and failed to clean the blood pressure monitor before or after use. During an interview on 9/11/2025 at 12:58 PM, the Director of Nursing (DON) confirmed that reusable equipment should be cleaned and disinfected between resident use.</p>