

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/22/2024
NAME OF PROVIDER OR SUPPLIER Memphis Jewish Home		STREET ADDRESS, CITY, STATE, ZIP CODE 36 Bazeberry Road Cordova, TN 38018	

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 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the Level 1 Pre-admission Screening and Resident Review (PASRR) form, medical record review, and interview, the facility failed to resubmit a PASRR after a resident had a new mental health diagnosis and new antipsychotic medication for 1 of 1 sampled resident (Resident #70) reviewed for PASRRs.</p> <p>The findings include:</p> <p>1. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE], with diagnoses including Dysphagia, Muscle Weakness, Dementia, and Anxiety.</p> <p>Review of the ICD -10 Diagnoses revealed Resident #70 had an added diagnosis of Psychotic Disorder with hallucinations on 3/30/2023.</p> <p>Review of the Physician Order dated 5/31/2024, revealed Resident #70 had an order for Quetiapine (an antipsychotic medication used to treat Psychosis) 50 mg(milligram) tablet to take one by mouth 2 hours before bedtime.</p> <p>Review of the quarterly Minimum Data Set, dated [DATE], revealed Resident #70 had a Brief Interview for Mental Status score of 10, which indicated the resident was moderately cognitively impaired, and had diagnosis of Psychotic Disorder, and the use of an Antipsychotic medication.</p> <p>Review of the Medication Administration Record (MAR) dated 10/2024 and 11/2024, revealed Resident #70 received the Quetiapine as prescribed.</p> <p>During an interview on 11/22/2024 at 11:58, the Resident Assessment Coordinator confirmed the facility failed to complete a Level 2 PASRR after the resident was given a mental illness diagnosis and given an order for an antipsychotic medication.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**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 the environment was free of accident hazards when unattended and unsecured sharps were observed in 1 of 119 (room [ROOM NUMBER]) occupied resident bathrooms.</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled Bloodborne Pathogens/Contaminated Sharps Occupational Exposure, dated 11/2021, revealed .Universal Precautions will be observed to prevent contact with blood and other potentially infectious materials. Sharps Containers will be provided to all staff to dispose of any potentially contaminated sharp, product or object that may have been exposed . 2. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE], with diagnoses including Parkinson's, Dementia, and Epilepsy. <p>Review of the Care Plan dated 3/13/2024, revealed .Self Care Deficit related to inability to independently perform Activities of Daily Living skills (ADLs) secondary to cognitive and physical deficit .</p> <p>Review of the annual Minimum Data Set assessment dated [DATE], revealed a Brief Interview of Mental Status score of 10, which indicated Resident #52 was moderately cognitively impaired and was dependent on staff for assistance with ADLs.</p> <p>Observation in room [ROOM NUMBER]'s bathroom on 11/18/2024 at 10:06 AM and 3:41 PM, revealed an unattended and unsecure disposable razor with the blades exposed on the bathroom vanity.</p> <p>During an interview and observation in room [ROOM NUMBER] on 11/18/2024 at 3:53 PM, the Director of Nursing (DON) was asked if the razor should be left in the resident's bathroom unsecured and unattended. The DON confirmed that the razor should not be left in resident's room or bathroom and that razors should be discarded in a sharps container after use.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to have a physician's order for the use of an indwelling urinary catheter (a tube inserted into the bladder that drains urine) for 1 of 3 (Resident #57) residents reviewed for the use of an indwelling catheter.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility policy titled, Appropriate Use of Indwelling Catheters, dated 8/2024, revealed . An indwelling urinary catheter will be utilized only when a resident's clinical condition demonstrates that catheterization is necessary .The use of an indwelling urinary catheter will be in accordance with physician orders . Review of the medical record reveled Resident #57 was admitted to the facility on [DATE], with diagnoses including Parkinson's, Dementia, Retention of Urine, and Benign Prostatic Hyperplasia. <p>Review of the annual Minimum Data Set, dated [DATE], revealed Resident #57 had a Brief Interview for Mental Status score of 11, which indicated the resident was moderately cognitively impaired, and did not have an indwelling urinary foley catheter.</p> <p>Review of the signed Physician Orders dated 10/01/2024 to 10/31/2024 and 11/01/2024 to 11/22/2024 revealed Resident #57 did not have an order for the use of an indwelling urinary catheter.</p> <p>Review of a Progress Note dated 10/9/2024, revealed .arrived at facility at 4:40 pm . indwelling foley catheter .</p> <p>Review of a Progress Note dated 10/10/2024, revealed .foley catheter intact and patent .</p> <p>Review of a Progress Note dated 10/14/2024, revealed .Foley catheter intact below bladder, draining properly .'</p> <p>Review of a physician's progress note dated 11/5/2024 revealed .Resident ready to get rid of the foley catheter .</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 1 of 15 (300 Hall Medication Cart) medication storage areas was observed unlocked and unsecured and when 1 of 4 staff (Licensed Practical Nurse (LPN A) left medications unsecured and unattended on top of a medication cart.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled Medication Storage, dated 1/2021, revealed .It is the policy of this facility to ensure all medication housed on our premises will be stored in the pharmacy and/or medication rooms .All drugs and biologicals will be stored in locked compartments (.medication carts, cabinets, drawers .) .During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart . 2. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Hypertension. <p>Review of the Physician's Order dated 8/8/2024, revealed Anoro Ellipta (an inhaler used to open the airway to assist in breathing) 62.5-25 mcg (micrograms) inhale one puff every day.</p> <p>Observations during medication administration on 11/20/2024 at 8:16 AM, revealed LPN A entered Resident #32's room to administer the resident's medications leaving an Anoro inhaler on top of the medication cart in the hallway unsecured and unattended.</p> <ol style="list-style-type: none"> 3. Random observation and interview on the 300 Hall on 11/20/2024 at 3:51 PM, revealed the 300 Hall medication cart unlocked and unattended with a drawer opened and Registered Nurse (RN) B was in a resident's room with the 300 hall medication cart out of her vision. RN B was asked should the medication cart be left unlocked, unsecured and out of her view. RN B confirmed the medication cart should be locked and no medication cart drawer should be let opened and unattended.