

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Graceland Rehabilitation and Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1250 Farrow Road Memphis, TN 38116	

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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility policy review, medical record review, Incident Reporting System (IRS), and interview the facility failed to report sufficient information to describe the results of all investigations to the State Survey Agency within 5 working days of the incident for 1 of 2 (Resident #515) sampled residents reviewed for an injury of unknown origin.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Abuse Investigations, dated 4/2010, revealed .Policy Statement .All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management .Should an incident .of unknown source be reported, the Administrator . will appoint a member of management to investigate the alleged incident .The Administrator will provide a written report of the results of all .investigations and appropriate action taken to the state survey and certification agency .within five (5) working days of the reported incident .</p> <p>Review of the facility policy titled, ACCIDENT & [and] INCIDENT DOCUMENTATION & INVESTIGATION RESIDENT INCIDENT, dated 7/2018, revealed .Accidents and/or incidents involving resident care will be investigated and documented on the Resident Incident Report entry form in the LTC [Long Term Care] system. An incident is defined as an occurrence which is not consistent with the routine operation of the facility or the routine care of a particular resident. Accidents and incidents will be analyzed for trends or patterns to enable the facility to enhance preventative measures to reduce the occurrence of incidents .The Executive Director/Director of Nursing will notify the State Department of Health in accordance with reporting guidelines in the event the accident/incident is reportable .</p> <p>2. Review of the medical record revealed Resident #515 was admitted to the facility on [DATE], with diagnoses which included Parkinson's Disease, Lack of Coordination, Muscle Weakness, and Repeated Falls.</p> <p>Review of Resident #515's care plan dated 12/5/2023, revealed .Focus .is at risk for falls r/t [related to] new and unfamiliar environment, poor safety awareness, unsteady gait, weakness .Interventions .Be sure the call light is within reach and educate the resident on use. Reinforce and encourage resident to call for assistance. Respond promptly to all requests for assistance as needed .</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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #515 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Continued review revealed Resident #515 required substantial/maximal assistance with sit to stand, chair/bed-to-chair transfer, toilet transfer was not attempted due to medical condition or safety concerns and dependent for walking 10 feet. Further review revealed Resident #515 had a fall in the last month.</p> <p>Review of the Progress Notes dated 1/7/2024 at 4:00 PM, revealed .Resident [#515] in room screaming 'help'. Upon entering room resident observed on floor leaning on left side a few feet from restroom door. Resident's w/c [wheelchair] observed on left side of resident's bed. Call light clipped onto resident's bed. No call light in use. Prior to fall this nurse witnessed resident sitting up on left side of bed. Resident c/o [complained of] pain to right hip and leg, requesting X-ray stating 'I can't move this side.' No redness/swelling nor abnormalities noted to right hip and leg at this time. No abnormalities noted to resident's head. ROM [Range of Motion] WNL [Within Normal Limit] to left leg and BUE [Bilateral Upper Extremity]. Resident assisted to w/c from bed via [by way of] total lift, staff x [times] 2. RP [Responsible Party] made aware. Unable to reach MD [Medical Doctor]. PRN [As needed] Tylenol admin [administered] for pain .</p> <p>Review of the Progress Notes dated 1/7/2024 at 6:40 PM, revealed, .New order per NP [Nurse Practitioner] to transfer resident [#515] to ER [Emergency Room] for eval. Medical transport contacted with 1.5hour ETA [Estimated Time of Arrival]. RP made aware .</p> <p>Review of the Progress Notes dated 1/7/2024 at 10:28 PM, revealed .Resident [#515] transferred to [Named Hospital #1] ER for eval. s/p [status post] fall .</p> <p>Review of the IRS revealed .Allegation Type .Other Not Listed .Facility became aware of the incident . 1/8/2024 11:00 AM .Name [Named Administrator] .Alleged Victim .[Named Resident #515] .Allegation Details .unwitnessed Fall .Date and time when the alleged incident occurred .1/07/2024 4:00 PM .residents [resident's] room .Provide details of any physical harm .resident complaints of right shoulder and hip pain . Provide all steps taken immediately to ensure resident(s) are protected .On 1/7/24 [2024] [Named Resident #515] was noted yelling for help in her room. Upon the nurse's arrival resident was noted lying on the floor on her left side in front of the bathroom door. The wheelchair was noted on the left side of the bed where the resident was last reported sitting on her bed. Resident was assisted to bed where full body audit was performed. Resident did report c/o [complaint of] right shoulder and hip pain. MD [Medical Doctor] notified and resident was sent to ER [Emergency Room] for evaluation per MD orders .ATTENTION: PLEASE INCLUDE ENOUGH INFORMATION IN THIS BOX TO EXPLAIN BRIEFLY WHAT OCCURRED AND WHAT YOUR IMMEDIATE INTERVENTION/S WAS .ADD also: Investigation initiated . The IRS box for the information was blank with no investigation submitted.</p> <p>Review of the complaint intake dated 1/8/2024 revealed, Follow up submitted the same day Right femoral fracture. Mrs. [Responsible Party] made aware @ 1600 [4:00 PM]. The intake revealed no interventions or investigation was noted in the follow up submission. The facility reported 1 sentence as their follow-up investigation and failed to provide in its report sufficient information to describe the results of the investigation, and indicate any corrective actions taken.</p> <p>During a telephone interview on 5/12/2025 at 6:51 AM, State Agency Intake Staff stated, .the facility did not submit a final investigation .</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/2025 at 5:16 PM, the Administrator was asked if the facility had reported incident to the state agency, when would the facility submit the final investigation. The Administrator stated, .In 5 days .		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and interview, the facility failed to notify the resident's representative or family member of the intent to discharge for 1 of 3 (Resident #316) sampled residents reviewed for discharge.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled, Transfer or Discharge ., dated 8/2018, revealed .Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures .Notify the representative (sponsor) or family member . 2. Review of the medical record revealed Resident #316 was admitted to the facility on [DATE], with diagnoses including Pulmonary Embolism, Myocardial Infarction, and Acute Kidney Failure. <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #316 was severely cognitively impaired.</p> <p>Review of the Nurse's Note dated 8/2/2023, revealed Resident discharged to [Named] Psychiatric Care, left via (by way of) stretcher in stable condition, denies pain and discomfort. Resident left with all his belonging. Community Service transport resident to [Named] Psychiatric Care .</p> <p>Review of the Social Services Note dated 8/2/2023, revealed Phone call made to [Named facility] .we will not be able to accept him back because of his elopement risk and that he's needing a lock down unit for his safeness [safety] .</p> <p>During a telephone interview on 5/8/2025 at 12:56 PM, the Resident's representative (RP) confirmed she was unaware of the facility's decision to discharge the resident, and the facility would not be accepting the resident back.</p> <p>During an interview on 5/12/2025 at 10:59 AM, the Social Services Director (SSD) confirmed that Resident #316's representative was not informed of the facility's intent to discharge the resident from the facility. The SSD confirmed that Social Services was responsible for informing the resident's representative of intent to discharge from the facility and the refusal to accept the resident back.</p> <p>During an interview on 5/13/2025 at 3:58 PM, the Director of Nursing (DON) confirmed that Social Services was responsible for informing residents and/or representative of intent to discharge. The DON confirmed that the communication with the representative regarding the facility's decision to discharge should be documented in the resident's medical record.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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 facility policy review, medical record review, facility investigation review, hospital record review, medical transport services record review, and interview, the facility failed to ensure residents remained free from accident hazards for 2 of 5 (Resident #415 and #515) sampled residents reviewed for accident hazards. The facility failed to ensure a vulnerable, non-verbal, cognitively impaired resident who required 2-person assistance with bed mobility and care, remained free from accident hazards as evidenced by failure to provide the required amount of assistance for safe repositioning and/or transfer, resulting in a significant injury and hospitalization for Resident #415. On 3/7/2025 at approximately 11:20 AM, Resident #415, a cognitively impaired Resident who was totally dependent on staff for mobility and required 2-person assistance with activities of daily living (ADLs) was receiving care from Certified Nursing Assistant (CNA) A and CNA B. CNA A and CNA B repositioned Resident #415 in the bed on to her side, CNA B then exited the Resident's room to get more supplies, and left CNA A in the room alone with Resident #415 who was still positioned on her side. According to staff, Resident #415's weight shifted, which caused the Resident to fall from the bed to the floor, and hitting her head which resulted in a large hematoma to the Resident's left side of the forehead. Resident #415 was transported to the emergency room on 3/7/2025 and remained hospitalized until 3/19/2025, with the admitting diagnosis of Focal Hemorrhagic Contusion of Cerebrum (a bruise to the brain caused by a head injury with bleeding and swelling). The facility's failure to provide an environment that was free from accident hazards resulted in an 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) for Resident #415. The facility also failed to provide an environment free from accident hazards when Resident #515, a moderately cognitively impaired resident, who required assistance with mobility, sustained an unwitnessed fall. Resident #515 was found by staff on the floor, reported to staff right leg pain and the inability to move her right leg and asked staff for an x-ray of her leg. Staff assisted the Resident to the bed then used a mechanical lift to move the Resident from the bed to a wheelchair. Staff waited a total of 6 hours and 28 minutes later to call Emergency Transport Services to transport the Resident to the hospital. At the hospital, Resident #515 was diagnosed with a Displaced Subcapital Right Femoral Neck Fracture (hip fracture that occurs when the bone in the neck of the thighbone breaks, and the bone fragments are no longer in proper alignment) which resulted in actual HARM to Resident #515.</p> <p>The Administrator was notified of the Immediate Jeopardy on 5/7/2025 at 4:55 PM, in the Conference Room.</p> <p>The facility was cited at F-689 at a scope and severity of J, which is substandard quality of care.</p> <p>An extended survey was conducted from 5/8/2025 to 5/13/2025.</p> <p>An acceptable Removal Plan which removed the immediacy of the Jeopardy for F-689 was received on 5/9/2025, and the Removal Plan was validated on-site by the surveyors on 5/13/2025 by medical record review, in-service record review, audit review, observation, and staff interviews.</p> <p>The Immediate Jeopardy for F689 began on 3/7/2025 through 5/8/2025, the IJ was removed on 5/9/2025.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's noncompliance at F-689 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions.</p> <p>The facility is required to submit a Plan of Correction.</p> <p>The findings included:</p> <p>1. Review of the facility policy titled, Safety and Supervision of Residents, dated July 2017, revealed .Our facility strives to make the environment as free from accidents and hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide priorities .Safety risks .are evaluated on an ongoing basis through a combination of employee training, employee monitoring and reporting processes . QAPI [Quality Assurance and Performance Improvement] review of safety and incident/accident data .when accident hazards are identified, the QAPI/safety committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards .Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents .Monitoring the effectiveness of interventions shall include the following . Ensuring that interventions are implemented correctly and consistently .</p> <p>Review of the facility policy titled, Repositioning, dated May 2013, revealed .The purpose of this procedure is to provide guidelines for evaluation of resident repositioning needs, to aid in the development of an individual's care plan for repositioning .review the resident's care plan to evaluate for any special needs . assemble the equipment and supplies as needed .encourage the resident to participate if able .two people .</p> <p>Review of the undated facility policy titled, Pain Management, revealed, .most common painful conditions occurring in long-term care residents .Fractures .Effective symptomatic treatment should not be withheld while a definitive diagnosis or cause of pain is identified .The Pain Evaluation prompts the licensed nurse to elicit from the resident or family members' approaches that make the resident's pain better or worse .factors that may increase pain include .Anxiety .Position .Just as the experience of pain is subjective, assessing another in pain is subjective .We must rely on behaviors observations, as well as intuition and personal judgment .</p> <p>2. Review of the medical record revealed Resident #415 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Cerebral Infarction, Chronic Obstructive Pulmonary Disease, and Dysphagia.</p> <p>Review of the Care Plan revealed .[1/02/2025] .[Resident #415] at risk for falls r/t [related to] unsteady gait . has bladder incontinence r/t limited mobility .has an ADL self-care deficit r/t .cerebral infarct [infarction/stroke] .has bowel incontinence r/t limited mobility .has dx [diagnosis] of Cerebral Vascular Accident [stroke] . impaired cognitive function or impaired thought processes r/t cognitive communication deficit .</p> <p>Review of the significant change Minimum Data Set (MDS) dated [DATE], revealed staff did not perform a Brief Interview for Mental Status (BIMS) score due to Resident #415's severe cognitive impairment. Resident #415 had short and long-term memory problems and cognitive skills for daily decision making indicated the resident had severe cognitive impairment. Resident #415 was dependent on staff for bathing, toileting, and personal hygiene, and was always incontinent of bowel and bladder.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Progress Notes dated 3/7/2025 at 12:17 PM, revealed LPN (Licensed Practical Nurse) G documented .CNA x2 [times 2] was assisting res [Resident #415] with ADLs .res was assisted onto her right side and [had] BM [bowel movement] CNA cleaned BM off of res. res had additional BM after clean linen was applied to bed. one cna [CNA B] stepped out of [the] room to get extra linen/towels. cna [CNA A] that remained in room continued to hold res onto her side. res tilted forwarded and fell onto floor. writer [LPN G] assessed res and noted raised area on left side of res' head. Writer [LPN G] called res' daughter/RP [responsible party] .at 1120 [11:20 AM] to report fall and that res would be transported to hospital foreval [for evaluation]. writer contacted [Medical Transport 1] for res to be transferred to [Named hospital 1] per hospital choice on profile. 1123 [11:23 AM] writer called [responsible party] back to answer additional questions after transportation was called .</p> <p>Review of the Situation Background Assessment and Recommendation (SBAR) Physician/Nurse Practitioner (NP)/Physician Assistant (PA) Communication Tool dated 3/7/2025 at 3:24 PM, revealed Resident #415 fell and was transported to the hospital because of a recent fall. Resident #415 had some confusion, a blood pressure of 172/91, and non-verbal indicators of pain were present.</p> <p>Review of the facility's investigation dated 3/7/2025, confirmed there were 2 staff in the room, 1 staff left the room to retrieve some linen, and Resident #415 fell from the bed, while the second staff member was out of the room.</p> <p>Review of the Hospital Medical Records Radiology results dated 3/11/2025, confirmed Resident #415 had a Traumatic Brain Injury (TBI) with left frontal (lobe of the brain), right temporal (lobe of the brain), parenchymal (the tissue that performs the organ's primary function; indicates damage or problem in the brain tissue) and subarachnoid hemorrhage (bleeding in the space between the brain and covering the tissue in the brain).</p> <p>Review of Hospital #1's HOSPITALIST DISCHARGE SUMMARY dated 3/19/2024, revealed Named Resident #415 was discharged to the facility on 3/19/2025.</p> <p>During a telephone interview on 5/7/2025 at 1:05 PM, CNA B stated, [Named Resident #415] required a 2 person assist on the day of the fall. CNA B confirmed she went to assist CNA A, Resident #415 had a large bowel movement, they did not have enough supplies in the room at that time, and CNA B was asked to go out of the room to get some rags [linens]. CNA B stated, I was in the hallway and CNA A called out 'She fell, she fell'. CNA B stated LPN G was called and nurse LPN G and CNA B went to the room after Resident #415 had fallen from the bed. CNA B stated, Resident #415 was too close to the edge of the bed, I guess.</p> <p>During a telephone interview on 5/7/2025 at 1:45 PM, CNA A stated CNA B exited the room to get supplies because Resident #415 had a bowel movement. CNA A stated she was standing behind Resident #415 when CNA B exited the room. CNA A stated Resident #415 shifted her weight away from her and she couldn't catch Resident #415, and the Resident fell to the floor. CNA A stated the Resident's bed height was waist high.</p> <p>During an interview on 5/13/2025 at 3:58 PM, the Director of Nursing (DON) was asked what occurred when Resident #415 fell out of the bed on 3/7/2025. The DON stated 2 CNAs were providing care to the Resident, they ran out of supplies, and one CNA stepped out of the room to get more supplies. The DON stated that the Resident's weight shifted, and the Resident fell out of bed onto the floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 5/13/2025 at 4:48 PM, the Administrator was asked what they determined the root cause was that resulted in Resident #415 falling out of the bed. The Administrator stated there were 2 CNAs in the Resident's room giving care to Resident #415 and one CNA exited the room to get additional supplies leaving one CNA with the Resident. The Administrator stated Resident #415's weight shifted, and the Resident fell from the bed onto the floor.</p> <p>The facility failed to maintain 2-person assistance while providing care to Resident #415 resulting in a fall with injury which placed the Resident in Immediate Jeopardy.</p> <p>3. Review of the medical record revealed Resident #515 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Lack of Coordination, Muscle Weakness, and Repeated Falls.</p> <p>Review of the Care Plan dated 12/5/2023, revealed .Focus .[Resident #515] is at risk for falls r/t new and unfamiliar environment, poor safety awareness, unsteady gait, weakness .</p> <p>Review of the admission MDS assessment dated [DATE], revealed Resident #515 had a BIMS score of 11, which indicated moderate cognitive impairment, and she</p> <p>required maximal assistance with ADLs.</p> <p>Review of the Progress Notes dated 1/7/2024 at 4:00 PM, for Resident #515 revealed .Resident in room screaming 'help'. Upon entering room resident observed on floor leaning on left side a few feet from restroom door .Resident c/o [complained of] pain to right hip and leg, requesting X-ray stating 'I can't move this side.' . Resident assisted to w/c [wheelchair] from bed via [by way of] total lift [mechanical device used to lift resident], staff x [times] 2. RP made aware. Unable to reach MD [Medical Director]. PRN [As needed] Tylenol admin [administered] for pain .</p> <p>The Progress Notes revealed the nurse moved Resident #515 using a mechanical lift after she voiced inability to move the right side and complained of pain.</p> <p>Review of the SBAR dated 1/7/2024, revealed .Situation .fall .1/7/2024 .Identify whether the problem/symptom has gotten worse/better/stayed the same since it started .Worse .Recent fall .Resident Reports Pain .Yes .Non-verbal indicators of pain evident .Yes .Describe appearance .in pain post fall .</p> <p>Review of the Progress Notes dated 1/7/2024 at 6:40 PM, revealed .New order per NP to transfer resident to ER [Emergency Room] for eval. Medical transport contacted with 1.5hour ETA [Estimated Time of Arrival]. RP made aware .</p> <p>Review of the Progress Notes dated 1/7/2024 at 10:28 PM, revealed .Resident transferred to [Named Hospital #1] ER for eval. s/p [status post] fall .</p> <p>The Progress Notes revealed the nurse did not make any further calls to other ambulance service transports or call 911 to address Resident #515's immediate needs.</p> <p>Review of the Progress Notes revealed Resident #515 stayed at the facility for 6 hours and 28 minutes before she was transferred to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Prehospital Care Report Summary from Medical Transport #2 revealed, .1/07/2024 Call# [number]: 0645 [6:45 PM] .Transport by This EMS [Emergency Management Services] Unit .Initial Patient [Resident #515] Acuity: Critical (Red) .Dispatched: 21:18 [9:18 PM] .Left Scene .22:03 [10:03 PM] . Falls/Back Injuries (Traumatic) .Patient Physical Limitations: Right Leg Paresis [a partial or incomplete loss of muscle function] .distal femur [thighbone] swelling pain 8/10 [pain scale of 1 being lowest and 10 being highest pain level] .unwitnessed fall with injuries Duration: 6 Hours .Extremity Trauma .AOSTF [Arrived on scene to find] [age in years of female] seated in wheelchair by door .stated pain 15 [when asked pain level on scale of 1 to 10] when moving, alert daughter and son-in-law present in pt [patient] room .pt found [found] seated in wheelchair, should not be seated until fracture/injury determined .</p> <p>Review of the typed facility investigation for Resident #515 revealed, .On 1/7/24 [2024], [Named Resident #515] was noted yelling for help in her room. Upon the nurse's arrival resident was noted lying on the floor on her left side in front of the bathroom door .MD notified and resident was sent to ER for evaluation per MD orders. 1/8/24 [2024] DON were [was] notified that [Named Resident #515] had sustained a displaced subcapital right femoral neck fracture from the admitting hospital .</p> <p>During an interview on 5/7/2025 at 9:40 PM, the Nurse Practitioner (NP) #1 stated, .I raised up concerns in a recent meeting .I expressed concerns about patient safety .fall education on proper body mechanics .I know of issues with falls with injury .</p> <p>During an interview on 5/12/2025 at 3:23 PM, the MD was asked about Resident #415's fall. The MD stated, . she was supposed to be a 2 person assist someone left to go get supplies and then the resident fell .fall protocol that I expect them [referring to nursing staff] to follow, it hasn't changed, my fall protocol specifically follows what happens after the fall, the resident should not have been left, it would take the 3rd person getting the supplies . MD was asked if the fall was preventable for Resident #415. The MD stated, Yes, never, ever leave the person in the room alone . The MD was asked about Resident #515's fall and what the nurse should have done when she was unable to reach the NP. The MD stated, .we have the call process and text process if they follow those steps, shouldn't be a long period of time to get in contact with me .the nurse should have called me . The MD was asked when Resident #515 had an unwitnessed fall, expressed she was unable to move her leg, and she requested x-rays what would he expect the nurse to do. The MD stated, .expect to send the resident out for x-ray .</p> <p>During a telephone interview on 5/13/2025 at 8:55 AM, Family Member (FM) AA was asked about Resident #515's fall on 1/7/2025. FM AA stated, .Mom kept calling saying she was hurting after she fell .she was calling me on the phone .I got at [to] the facility .I told the nurse she is screaming in pain, I think we need an Xray and sent out to the hospital .the ambulance didn't come quick .I started to call 911 but the nurse told me it wasn't an emergency then we find out at the hospital her leg was broken . FM AA stated, .I stayed at the facility until she was transported out .she was in terrible pain and couldn't move her right leg .she was yelling .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445331	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Graceland Rehabilitation and Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1250 Farrow Road Memphis, TN 38116	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 5/13/2025 at 12:27 PM, Licensed Practical Nurse (LPN) KK was asked if she recalled a fall which involved Resident #515 on 1/7/2025 when she was on duty and assessed the resident. LPN KK stated, .I don't remember that incident . This surveyor read LPN KK's Progress Notes dated 1/7/2025. LPN KK stated, .now I remember .she was in pain .she kept hollering, eventually got transport to send her out .most times they [referring to the facility] don't want us to use 911 . LPN KK was asked when she would activate 911. LPN KK stated, .if patient was unresponsive . LPN KK was asked why she moved the resident from the floor with the lift. LPN KK stated, .She [Resident #515] wasn't assisting .</p> <p>During an interview on 5/13/2025 at 2:35 PM, the DON was asked if a resident had an unwitnessed fall, voiced the inability to move her leg, and complained of pain after being found on the floor would she expect the nurse to get the resident up. The DON stated, .I would expect the nurse to leave them in place . The DON was asked why she would not want the resident to be moved. The DON stated, .it could cause more injury and possibly cause the resident more pain .</p> <p>During an interview on 5/13/2025 at 5:16 PM, the Administrator was asked if an ambulance transport was unable to arrive for 1.5 hours for a resident who experienced an unwitnessed fall, was unable to move her leg, and experienced pain what would she expect the nurse to do. The Administrator stated, .call 911 .</p> <p>An acceptable Removal Plan which removed the immediacy of the Jeopardy was received on 5/9/2025 at 3:52 PM. The surveyors validated the Removal Plan by record review, review of facility audits, in-service sign-in sheets, observations, and interviews.</p> <p>An Assessment of Compliance (AOC) was conducted on 05/07/2025 to evaluate the appropriate implementation and documentation of 2-person assist with bed mobility at Graceland Rehabilitation and Nursing Center. This assessment included a fall incident audit and a review of care plans and [NAME]'s for accuracy and alignment with residents' current bed mobility needs.</p> <p>The facility immediately educated CNA A and CNA B on 2-person assist with bed mobility and positioning and repositioning the resident while providing care, reviewed all falls, policies, [NAME]'s and care plans to align with each resident's current bed mobility needs. Immediately began in-servicing on Fall Management Program, Safety and Supervision of the Resident and Positioning and Repositioning of the resident for all licensed Nurses, CNAs and Respiratory Therapist.</p> <p>The root cause was CNA B left the room to get more supplies leaving CNA A alone in the room with Resident #415. CNA A and B were aware that resident #415 was a 2-person assist with bed mobility.</p> <p>The facility has implemented Fall audits, Care plan audits, [NAME] audits, Policy audits, and on-going education with Licensed Nurses, CNAs and Respiratory Therapist on 2-person assist with bed mobility to call for help and not leave the room if they need any supplies, skills competency with positioning and repositioning residents with return demonstration to prevent recurrence.</p> <p>The facility is monitoring all falls daily, ensuring all care plans and [NAME]'s are up to date and on-going competencies and education to ensure training is effective.</p> <p>The facility is measuring effectiveness of the in-services by monitoring the falls on a daily basis and observing return demonstrations through competency.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Graceland Rehabilitation and Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1250 Farrow Road Memphis, TN 38116	

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Fall Audit:</p> <p>A facility wide fall audit was conducted on 05/07/2025 from 03/07/2025 to current with no major injuries. No fall concerns with 2-person assist with bed mobility.</p> <p>Care Plan Audit:</p> <p>A facility wide care plan audit was conducted on 05/07/2025 to ensure any resident that is a 2- person assist reflects accurately and was found to be up to date.</p> <p>[NAME] Audit:</p> <p>A facility wide [NAME] audit was conducted on 05/07/2025 to ensure all residents had an up-to-date [NAME] and aligning with current care plan with 2-person assist with bed mobility. All [NAME]'s were found to be accurate.</p> <p>Policy Audit:</p> <p>Policies on Fall Prevention Program, Safety and Supervision of Residents, and Repositioning were all reviewed by the Administrator and Director of Nursing on 05/07/2025 with no revisions needed.</p> <p>Education:</p> <p>All licensed Nurses, CNAs, Respiratory Therapist, any nursing agency personnel and any Nurses, CNAs, Respiratory Therapist on Leave of Absence (LOA) will be in-serviced on Fall Prevention, Safety and Supervision of Residents, and Repositioning starting on 05/07/2025.</p> <p>Quality Assurance Improvement Plan (QAPI):</p> <p>The facility is continuing its on-going Quality Assurance Plan to monitor facility performance and compliance with the Fall Prevention Program, Safety and Supervision of Residents, and Repositioning by continuing to monitor falls daily and implementing planned interventions and approaches appropriately.</p> <p>Conclusion:</p> <p>(Named facility) remains committed to ensuring resident safety through proper documentation and adherence to mobility assistance requirements. Continued monitoring and education will be conducted to maintain compliance and prevent future incidents.</p>