

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2024
NAME OF PROVIDER OR SUPPLIER Midtown Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 141 N McLean Blvd 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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439</p> <p>Based on policy review, medical record review, and interview, the facility failed to provide education for Advance Directives to residents or resident's responsible parties for 33 of 34 sample residents (Resident #12, #22, #23, #27, #29, #30, #43, #50, #51, #58, #71, #86, #91, #92, #95, #97, #98, #105, #107, #112, #123, #124, #127, #137, #150, #151, #153, #154, #156, #157, #171, #174, and #229) reviewed for Advanced Directives.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's policy titled Advance Directives Policy, dated 2/20/2024, revealed .It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. Advanced directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated .The facility will provide the resident or resident representative information about the right to refuse medical or surgical treatment and formulate an advance directive . 2. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Neurogenic Bladder, Dysphagia, Rheumatoid Arthritis, Psychosis, and Hypothyroidism. <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated cognitive intact.</p> <ol style="list-style-type: none"> 3. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Anxiety, Atrial Fibrillation, and Psychosis. <p>Review of the significant change MDS dated [DATE] revealed Resident #22 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment.</p> <ol style="list-style-type: none"> 4. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Anxiety, Diabetes, Cerebral Infarction, Cancer of Kidney, and Schizophrenia. <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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #23 had a BIMS score of 14, which indicated the Resident was cognitively intact.</p> <p>5. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Diabetes, Gastrostomy, and Dementia.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #27 had severe cognitive impairment. The facility was unable to perform a BIMS test.</p> <p>6. Review of the medical record revealed Resident #29 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Aphasia, and Dysphagia.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #29 had a BIMS of 9, which indicated the Resident had moderate cognitive impaired.</p> <p>7. Review of the medical record revealed resident #30 was admitted to the facility on [DATE], with diagnosis including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Dementia, and Thyrotoxicosis.</p> <p>Review of the quarterly MDS dated [DATE] revealed Resident #30 had a BIMS score of 11, which indicated the Resident had moderate cognitive impairment.</p> <p>8. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE], with diagnoses including Peripheral Vascular Disease, Glaucoma, Coronary Artery Disease, and Anxiety.</p> <p>Review of the annual MDS dated [DATE] revealed Resident #43 had a BIMS score of 12, which indicated the Resident had moderate cognitive impairment.</p> <p>9. Review of the medical record revealed Resident #50 was admitted to the facility on [DATE], with diagnoses including Chronic Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Cerebral Infarction, Diabetes.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #50 had a BIMS score of 15, which indicated the Resident was cognitively intact.</p> <p>10. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Encephalopathy, Diverticulosis, Pulmonary Edema, Diabetes, and Sepsis.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #51 had a BIMS of 11, which indicated the Resident had moderate cognitive impairment.</p> <p>11. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE], with diagnoses including Atherosclerotic Heart Disease, Anxiety, Hypertension, and Heart Failure.</p> <p>Review of the Quarterly MDS dated [DATE], revealed Resident #58 had a BIMS score of 9, which indicated the Resident had moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12. Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Urinary Retention, Congestive Heart Failure, Chronic Respiratory Failure, and Cardiomyopathy.</p> <p>Review of the annual MDS dated [DATE], revealed Resident #71 had a BIMS score of 15, which indicated the Resident was cognitively intact.</p> <p>13. Review of the medical record revealed Resident #86 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Diabetes, Heart Failure, Psychotic Disorder, and Anxiety.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #86 had a BIMS score of 00, which indicated the Resident had severe cognitive impairment.</p> <p>14. Review of the medical record revealed Resident #91 was admitted to the facility on [DATE], with diagnoses including Dysphagia, End Stage Renal Disease, Breast and Colon Cancer, Muscle Weakness, Metabolic Encephalopathy, Hypertension, Pressure Ulcer Stage 3 of Right Buttocks and Left Buttocks, and Severe Protein Malnutrition.</p> <p>Review of the admission MDS dated [DATE], revealed Resident #91 had a BIMS of 4, which indicated the Resident had severe cognitive impairment.</p> <p>15. Review of the medical record revealed Resident #92 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, Depression, and Atrial Fibrillation.</p> <p>Review of the annual MDS dated [DATE] revealed Resident #92 had a BIMS score of 6, which indicated the Resident had severe cognitive impairment.</p> <p>16. Review of the medical record revealed Resident #95 was admitted to the facility on [DATE], with diagnoses including Bipolar Disorder, Anxiety, Dementia, and Rheumatoid Arthritis.</p> <p>Review of the quarterly MDS dated [DATE] revealed Resident #95 had a BIMS score of 13, which indicated the resident was cognitively intact.</p> <p>17. Review of the medical record revealed Resident #97 was admitted to the facility on [DATE], with diagnoses including Peripheral Vascular Disease, Diabetes, and Vitamin D Deficiency.</p> <p>Review of the quarterly MDS dated [DATE] revealed Resident #97 had a BIMS score of 13, which indicated the Resident was cognitively intact.</p> <p>18. Review of the medical record revealed Resident #98 was admitted to the facility on [DATE], with diagnoses including Senile Degeneration of Brain, Diabetes, Functional Quadriplegia, Benign Prostatic Hyperplasia, Cerebral infarction, and Hypothyroidism.</p> <p>Review of the quarterly MDS dated [DATE], revealed a BIMS score of 00, which indicated Resident #98 was severely cognitively impaired.</p> <p>19. Review of the medical record revealed Resident #105 was admitted to the facility on [DATE], with diagnoses including Complete Intestinal Obstruction, Morbid Obesity, Dyspnea, and Cellulitis.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>27. Review of the medical record revealed Resident #151 was admitted to the facility on [DATE], with diagnoses including Spondylosis, Anxiety, Spinal Stenosis, and Pressure Ulcer of Sacral Region.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #151 had a BIMS of 12, which indicated the Resident was cognitively intact.</p> <p>28. Review of the medical record revealed Resident #153 was admitted to the facility on [DATE], with diagnoses including Nontraumatic Intracerebral Hemorrhage, Diabetes, Cerebral Infarction, and Dementia.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #153 had a BIMs of 8, which indicated the resident had moderate cognitive impairment.</p> <p>29. Review of the medical record revealed Resident #154 was admitted to the facility on [DATE], with diagnoses including Encephalopathy, End Stage Renal Disease, Seizures, Anemia, and Dementia.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #154 had a BIMS score of 11, which indicated the Resident had moderate cognitive impairment.</p> <p>30. Review of the medical record revealed Resident #156 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Congestive Heart Failure, Diabetes, and Atrial Fibrillation.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #156 had a BIMS score of 11, which indicated the Resident had moderate cognitive impairment.</p> <p>31. Review of the medical record revealed Resident #157 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Esophageal Cancer, Hypertension, and Anxiety.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #157 had a BIMS score of 14, which indicated the Resident was cognitively intact.</p> <p>32. Review of the medical record revealed Resident #171 was admitted to the facility on [DATE], with diagnoses including Anemia, Colon Cancer, Dysphagia, Atelectasis, and Altered Mental Status.</p> <p>Review of the quarterly MDS dated revealed Resident #171 had a BIMS of 7, which indicated the Resident had severe cognitive impairment.</p> <p>33. Review of the medical record revealed Resident #174 was admitted to the facility on [DATE], with diagnoses including Encephalopathy, Diabetes, Dementia, Hypokalemia, and Systemic Lupus Erythematosus.</p> <p>Review of the admission MDS dated [DATE], revealed Resident #174 had a BIMS score of 6, which indicated the Resident had severe cognitive impairment.</p> <p>34. Review of the medical record revealed Resident #229 was admitted to the facility on [DATE], with diagnoses including Nontraumatic Intracerebral Hemorrhage, Vitamin B12 Deficiency, Cerebral Infarction, Bacteremia, and Schizophrenia.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the admission MDS dated [DATE], revealed Resident #229 had a BIMS score of 5, which indicated the Resident had severe cognitive impairment.</p> <p>35. During an interview on 8/26/2024 at 11:34 AM, the Administrator was asked who was responsible for the Advance Directive. The Administrator stated, .on admission it's the Admission Director .and then Social Services does it 48 hours after admission . The Administrator was asked should residents be offered advance Directive, educated and given opportunity to formulate on admission. The Administrator stated, Yes, Ma'am. The Administrator confirmed the facility had done a 100% audit of advance directive since the survey team had made her aware of the advance directives. The Administrator confirmed advance directive should be done on admission.</p> <p>The facility was unable to provide documentation that the Advance Directives had been offered to Resident #12, #22, #23, #27, #29, #30, #43, #50, #51, #58, #71, #86, #91, #92, #95, #97, #98, #105, #107, #112, #123, #124, #127, #137, #150, #151, #153, #154, #156, #157, #171, #174, and #229.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** 46047</p> <p>Based on policy review, medical record review, and interview, the facility failed to report allegations of abuse for 4 of 12 residents (Residents #35, #43, #107 and #157) sampled for abuse.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility policy titled, Abuse, Neglect and Exploitation, dated 4/3/2024, revealed .It is the policy of the facility to provide protections for the .welfare and rights of each resident .that prohibit and prevent abuse .Abuse .includes verbal abuse .willfully includes .derogatory terms to residents .within hearing distance .Reporting of all alleged violations to the Administrator, state agency .and to all other required agencies .within a specified timeframes .Not later than 24 hours if the events .do not result in serious bodily injury . Review of the medical record revealed Resident #157 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Malignant Neoplasm of Esophagus, Anxiety, and Depression. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15 which indicated Resident #157 was cognitively intact. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental (BIMS) score of 14 which indicated Resident #157 was cognitively intact. Review of the Investigation Staff to Resident Allegation, dated 8/21/2024, revealed .Notifications (complete all that apply) .Physician .[Named Physician] .8/21/24 1530 .Family .[Named Family Member] .8/21/24 1545 . What happened .CNA [certified nursing assistant] .constantly asking her [resident] when she was going home and that she did not need to be here. [Resident] voiced .made her feel nervous and upset . Review of the facility investigation provided, revealed the allegation of verbal abuse was not reported. During an interview on 9/3/2024 at 2:00 PM the Director of Nursing (DON) was asked if the allegation of abuse was reported to the state agency. She stated that after talking to the resident they didn't feel it was abuse and did not report the allegation. <p>3. Review of the medical record revealed Resident #107 was admitted to the facility on [DATE], with diagnoses including Cerebral Infraction and Schizoaffective Disorder. Review of the quarterly MDS assessment dated [DATE], revealed Resident #107 had BIMS score of 15, which indicated cognitively intact. Review of a named police department Incident Report dated 8/26/2024 at 8:44 AM, revealed Resident #35 alleged that Resident #107 had been physically aggressive toward Resident #107.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE], with diagnoses including Anxiety and Hypertension.</p> <p>Review of the annual MDS dated [DATE], revealed Resident #43 had a BIMSs score of 12, which indicated moderately cognitively impaired.</p> <p>Review of a named police department Incident Report dated 8/26/2024 at 8:44 AM, revealed Resident #43 alleged that Resident #107 had been physically aggressive toward Resident #107.</p> <p>During an interview on 8/27/2024 at 3:45 PM, the Administrator confirmed she was made aware on 8/26/2024, of an allegation that Resident #107 had been physically aggressive with Resident #43 on 8/23/2024.</p> <p>5. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE], with diagnoses including Osteoarthritis and Cerebral Infraction.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #35 had a BIMS score of 12, which indicated moderately cognitively impaired.</p> <p>Review of a named police department Incident Report dated 8/26/2024 at 8:44 AM, revealed Resident #35 alleged that Resident #107 had been verbally aggressive toward her.</p> <p>Review of the Incident Reporting System sheet revealed Resident #35's allegation of verbal abuse was not reported to the state until 8/27/2024 at 5:30 PM.</p> <p>The facility failed to report an allegation of resident-to-resident abuse in a timely matter.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33379</p> <p>Based on policy review, medical record review, facility investigation, named Police Department Incident Report, and interview, the facility failed to thoroughly investigate alleged incidents of resident-to-resident abuse for 3 of 12 sampled residents (Resident #35, #43 and #107) reviewed for abuse and failed to submit a 5-day follow up report to the state in a timely matter for 2 of 5 sampled residents (Resident #58 and #98) reviewed for abuse.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 4/3/2024, revealed .It is the policy of this facility to .An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur .Provide complete and thorough documentation of the investigation .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include .Responding immediately to protect the alleged victim .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury .The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies .</p> <p>2. Review of the medical record revealed Resident #107 was admitted to the facility on [DATE], with diagnoses including Cerebral Infraction, Spinal Stenosis, Schizoaffective Disorder, and Hemiplegia and Hemiparesis following cerebral infraction affecting left non-dominant side</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #107 had Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition.</p> <p>3. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE], with diagnoses including Anxiety and Hypertension,</p> <p>Review of the annual MDS assessment dated [DATE], revealed resident #43 had a BIMS score of 12, which indicated moderately impaired cognition.</p> <p>Review of a [named police department] Incident Report dated 8/26/2024 at 8:44 AM, revealed Resident #35 alleged Resident #107 was physically aggressive toward Resident #107.</p> <p>The facility failed to present a thorough investigation of the allegation Resident #107 was physically abusive toward Resident #43.</p> <p>4. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE] with diagnoses including Osteoarthritis, Cerebral Infraction, and Pain in Right Knee.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the quarterly MDS assessment dated [DATE] revealed a Brief interview for Mental Status BIMS score of 12, which indicated Resident #35 was moderately cognitively impaired.</p> <p>Review of a [named police department] Incident Report dated 8/26/2024 at 8:44 AM, revealed Resident #35 alleged that Resident #107 was verbally aggressive toward her.</p> <p>Review of the facilities investigation revealed after the facility became aware on 8/26/2026 of Resident #35's allegation of verbal abuse, there were no statements from witness', nor from the perpetrator, or alleged victim until 8/27/2024. There were no interventions to prevent the verbal abuse, until 8/27/2027 at 5:00 PM for Resident #35 and until 8/27/2024 at 3:00 PM for Resident #107. The facility failed to provide dates for the Staggered Smoking Breaks for Resident #35 and Resident #107. There were no in-services related to verbal abuse until 8/27/2024.</p> <p>The facility failed to present a thorough investigation of Resident #35's allegation of verbal abuse.</p> <p>During an interview on 8/27/2024 at 3:45 PM, the Administrator confirmed verbal aggression is a form of abuse and she was not made aware of Resident #35's allegation of verbal abuse on 8/26/2024 until 8/27/2024.</p> <p>During an interview on 8/28/2024 at 11:49 AM, the Social Worker confirmed on Monday Morning, 8/26/2024, she was informed by Resident #35 that during a smoke break on 8/25/2024, Resident #107 used profane language to address Resident #35.</p> <p>The facility failed to thoroughly investigate allegations of abuse.</p> <p>5. Review of the medical record revealed Resident #58 was admitted on [DATE] with diagnoses including Atherosclerotic Heart Disease, Anxiety, Hypertension, and Heart Failure.</p> <p>Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 11, which indicated Resident #58 was moderately cognitively impaired.</p> <p>Review of the Facility Reported Incident revealed, .Date and time of occurrence: 2/8/2024 10:55:00 AM . became aware of the incident on 2/8/2024 10:55:00 AM .facility reported .Physical Abuse .Employee was immediately removed from the hall and placed on suspension pending investigation .heard resident holler out you are smothering me .stop hitting me .Social Services, MD [medical doctor] and family made aware. Abuse in-service immediately initiated .</p> <p>Review of the Incident Reporting System sheet revealed Resident #58's allegation of staff to resident abuse 5-day follow up was not submitted to the state until 9/5/2024.</p> <p>During an interview on 9/4/2024 at 9:21 AM, the Administrator was asked who is responsible to report the 5 day follow up to the state. The Administrator stated, .the 5 day is myself or the DON . The Administrator confirmed she didn't see that the 5 day follow up had been done.</p> <p>6. Review of the medical record revealed Resident #98 was admitted to the facility on [DATE] with diagnoses including Senile Degeneration of Brain, Diabetes, Functional Quadriplegia, Benign Prostatic Hyperplasia, Cerebral Infarction, and Hypothyroidism.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Annual MDS assessment dated [DATE], revealed a BIMS score of 00, which indicated Resident #98 was severely cognitively impaired and was not coded for behaviors.</p> <p>Review of the Facility Reported Incident revealed, .Date and time of occurrence: 1/29/2024 4:15:00 AM .The facility reported the following [Named Resident # [NAME]] .hit [Named Resident #98] on the face on left side, discoloration noted to left side face .aggressor placed on 1:1 .Law enforcement and Ombudsman notified .5 day follow up report not submitted .</p> <p>Review of the Incident Reporting System sheet revealed Resident #98's allegation of resident-to-resident abuse 5-day follow up was not submitted to the state until 9/5/2024.</p> <p>During an interview on 9/4/2024 at 9:30 AM, the Administrator confirmed that she could not find the 5 day follow up to the state and stated, .I'm honest .didn't do it .</p>

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<p>F 0677</p> <p>Level of Harm - 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure a resident who was unable to carry out activities of daily living (ADL) was provided nail care for 1 of 4 (Resident #105) sampled residents reviewed for activities of daily living. The facility's failure to ensure toenail care was provided resulted in Actual Harm when Resident #105's skin was adhered to a long toenail, causing the resident pain.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Activities of Daily Living (ADLs), dated 2/2024, revealed .Care and services will be provided for the following activities of daily living .grooming .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain .grooming and personal hygiene .</p> <p>Review of the facility policy titled, Nailcare, dated 4/1/2024, revealed .Assessments of resident nails will be conducted on admission .to determine the resident's nail condition, needs .Routine cleaning and inspection of nail will be provided during ADL care on an ongoing basis .Routine nail care .will be provided at regular intervals .</p> <p>Review of the Admission Packet Document titled, Resident Rights, revealed .The resident has the right to a dignified existence .inside and outside the facility .</p> <p>2. Review of the medical record revealed Resident #105 was admitted to the facility on [DATE], with diagnoses including Muscle Weakness, Pain, and Need for assistance with Personal Care.</p> <p>Review of the physician orders revealed .Start Date .4/7/2024 .Consultation for Podiatry .as needed for patient health and comfort .</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #105 was cognitively intact and dependent on staff for personal hygiene.</p> <p>Review of the care plan dated 6/24/2024, revealed Resident #105 had a self care deficient and was dependent on staff for ADLs.</p> <p>During an interview on 8/18/2024 at 4:31 PM, Resident #105 stated, I need my toenails cut, they have not been cut since I have been here. They look like a freak show.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Observation in the resident's room on 8/20/2024 at 10:21 AM, revealed Resident #105 asked the surveyor when she was going to get her toenails cut. The toenails were making the socks poke out due to their length. LPN K was asked to Resident 105's room by the surveyor and asked to remove Resident #105's socks. Resident #105 told LPN K that she was hurting her while she was moving her toes and looking at the nails. Resident #105's toenails on the left foot were thick, long and extended past the tips of the toes about 1/4 of an inch. The right foot toenails were thin and extended past the tips of the toes. LPN K didn't want to trim the right foot big toenail because she felt the skin was attached to the nail. She stated she was going to try to trim the other nails. LPN K confirmed the Resident was on the podiatry list for the week.</p> <p>Review of the progress notes revealed, 08/21/2024 03:09 PM [Named Resident #105] .informed that podiatry has cancelled and has been rescheduled for 9/5/24 [2024], 9/12/24 and 9/24/24, though [Named Resident #105] was scheduled for outside podiatry visit today .</p> <p>During an interview on 8/21/24 at 10:28 AM, the Social Work Director confirmed podiatry cancelled visit today and won't be back until September.</p> <p>Resident #105 was on the list to be seen by the onsite Podiatry Company, that had cancelled the 8/21/2024 facility onsite visit. The facility scheduled an outside appointment after the facility onsite podiatry company cancelled.</p> <p>During an interview on 8/22/24 at 8:24 AM, Resident #105 stated she went to the podiatrist (outside of the facility) yesterday [8/21/2024] and had her toenails cut. She stated, .my toes feel a lot better. They don't hurt anymore .</p> <p>During an interview on 8/22/2024 at 12:20 PM, Resident #105 was asked if her toenails hurt before they were cut. Resident #105 stated, Yes, my toenails were painful.</p> <p>During an interview on 9/3/2024 at 10:35 AM, the 3rd floor Assistant Director of Nursing (ADON) confirmed nails should be assessed two times a week and staff should have noticed the nail length before 8/18/2024, when the surveyor brought the resident's long and painful toenails to the facility's attention.</p> <p>During an interview on 9/3/2024 at 4:54 PM, Resident #105 was asked how her toenails were, she stated, . feels like I have new feet .</p> <p>Resident #105 was admitted to the facility on [DATE] and there was a physician's order for a podiatry consult dated 4/7/2024. The facility failed to provide podiatry services until 8/21/2024 when Resident #105's toenails were long, painful, and the right big toenail was attached to the skin, which caused pain to the resident.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33379</p> <p>Based on medical record review, and interview the facility failed to provide appropriate care and services for wounds (non-pressure ulcer/injury wounds) for 2 of 10 (Residents #123 and #479) reviewed for wounds.</p> <p>The findings include:</p> <p>1. Review of medical record revealed Resident #123 was admitted to the facility on [DATE], with diagnoses including Peripheral Vascular Disease (PVD), Diabetes, Neuropathy, Chronic Kidney Disease, Acquired Absence of Left Leg Below Knee, and Metabolic Encephalopathy.</p> <p>Review of Resident #123's Right Lower Extremity Arterial Duplex Ultrasound dated 3/19/2024, revealed .Mild to moderate PAD [Peripheral Artery Disease]. Below-knee monophasic [one phase] flow consistent with distal trifurcation [the act of splitting or dividing into three branches] disease .</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #123 had a BIMS score of 5, which indicated Resident #123 had severe impaired cognition. Functional status was coded to reveal the resident was totally dependent on others for ADL's.</p> <p>Review of Resident #123's care plan effective date 7/30/2024, revealed .Resident has vascular/multifactorial -Right Heel [identified on 2/20/2024 as a pressure ulcer/injury] -Right Ankle [identified on 5/7/2024] vascular/multifactorial: Resident is at risk for further skin breakdown .</p> <p>Review of Resident #123's care plan with effective date of 8/5/2024, revealed . Wound-NP reclassified all pressure ulcers above to Vascular Ulcer .has Peripheral Vascular Disease [PVD] with potential for complications aeb [as evidenced by] Previous Pressure Ulcers reclassified .on (8/5/24) as Vascular Ulcer-Right Heel, Vascular Ulcer-Right Ankle, and Vascular Ulcer-Right Lateral Midfoot resolved .Observe PRN [as needed] any s/sx [signs and symptoms] of skin problems related to PVD: Redness, Edema, Blistering, Itching, Burning, Bruises, Cuts, other skin lesions .</p> <p>Review of Resident #123's INTEGRATED WOUND CARE Follow-up Progress Note dated 8/05/2024, revealed .vascular and diabetic right ankle was observed and documented with moderate serosanguinous exudate with 60% slough and 40% dermis .the wound measured 2.2 cm x 2.5 cm x 0.3 cm .Cleanse with dakins [topical antiseptic to treat and prevent infections], pat dry, apply honey followed by xeroform then gauze wrap QD [every day]/[and] prn [as needed] .</p> <p>Review of Resident #123's Wound Detail Report dated 8/7/2024, revealed .arterial ulcer right ankle wound 0.6 cmx 1.2 cm x 0.3 cm with purulent (opaque, milky; sometimes green) tissue type Necrotic Tissue .</p> <p>Review of Resident #123's INTEGRATED WOUND CARE Follow-up Progress Note dated 8/16/2024, revealed .vascular and diabetic right ankle was observed and documented with moderate serosanguinous exudate with tissue type 60% slough and 40% granulation .the wound measured 2.3 cm x 1.9 cm x 0.3 cm . Cleanse with dakins, pat dry apply honey followed by xeroform then gauze wrap QD /prn .</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #123's physician orders dated 8/17/2024, revealed .Cleanse vascular and diabetic right ankle with dakins pat dry apply hydrogel silver followed by xeroform then gauze wrap daily and prn .</p> <p>Review of Resident #123's INTEGRATED WOUND CARE Follow-up Progress Note dated 8/23/2024, revealed .vascular and diabetic right ankle was observed and documented with light serosanguinous exudate with tissue type 40% slough and 60% dermis .the wound measured 2.0 cm x 1.5 cm x 0.3 cm .recommend empiric abx [antibiotic] (bactrim ds bid [two times a day] x [for] 10 days) for infection .</p> <p>Review of Resident #123's progress note dated 8/26/2024, revealed .RIGHT HEEL .PURULENT DRAINAGE .the wound had drainage Friday .ABT [antibiotic] was recommended .</p> <p>During an interview on 8/26/2024 at 2:40 PM, LPN C confirmed the progress note from 8/23/2024 and 8/26/2024 were observations made by the Wound NP and herself (LPN C), on those days.</p> <p>Observation and interview in the resident's room with LPN C on 8/26/2024 at 2:45 PM, revealed Resident #123's arterial right ankle wound as a round area with 50% slough with purulent white drainage with a foul odor, measuring 2.0 cm x 1.5 cm x 0.3 cm. LPN C stated, .we recognized on Friday [8/23/2024] of purulent drainage .NP seen the wound on 8/23/2024 and made a recommendation for an antibiotic .the wound is worse today I reached out [called] to NP yesterday LPN C was asked when the Wound NP last saw the wound. LPN C stated, .the wound NP seen the wound Friday (8/23/2024) and today (8/26/2024). LPN C was asked when the antibiotic should have been started. LPN C stated, We [Wound NP and LPN C] saw the wound appearance was worse on 8/23/2024 and we should have wrote [written] an order that day. LPN C was asked if it takes 4-5 days to start a recommended antibiotic for an infected wound. LPN C stated, . sometimes .we just reach out [call/communicate] to NP for an order of the recommended antibiotic . LPN C was asked did you contact the MD. LPN C stated, We usually call NP or 3rd Eye [after hour on-call agency] . LPN C was asked if the wound appeared worse today (8/26/2024) than on Friday 8/23/2024. LPN C stated, . the odor is there and there is purulent drainage .yes it may be worse today [than it was on 8/23/2024] .</p> <p>Review of Resident #123's physician order dated 8/27/2024, revealed .Bactrim DS [Trimethoprim/[and] Sulfamethoxazole] .800-160 mg .1 oral twice a day for 10 days for wound healing .</p> <p>The facility failed to start Resident #123's recommended antibiotic (Bactrim DS 800-160 mg for 10 days) for wound healing on 8/23/2024. The antibiotic was started 5 days later on 8/27/2024.</p> <p>Review of Resident #123's INTEGRATED WOUND CARE Follow-up Progress Note dated 8/30/2024, revealed .vascular and diabetic right ankle was observed and documented with moderate serosanguinous exudate with tissue type 30% slough and 30% dermis, 10% eschar and 30% granulation .the wound measured 2.0 cm x 1.5 cm x 0.3 cm .cleanse with dakins, pat dry, apply hydrogel silver followed by xeroform then gauze wrap QD [every day]/ [and] PRN [as needed] . bactrim ds bid x 10 days. Needs vascular consult d/t [due to] lack of improvement in wounds .culture obtained last week .</p> <p>During an interview on 9/4/2024 at 10:10 AM, the Wound NP was asked why Resident #123's wounds were re-classified 5 months after the Right Lower Extremity Arterial Duplex Ultrasound. The Wound NP did not give an answer for the question.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/4/2024 at 11:30 AM, the DON was asked if a resident had a recommendation for an antibiotic from the Wound NP for an infected wound, should that Resident with an infected wound wait 5 days for an antibiotic to be started. The DON stated, No. The DON was asked why Resident #123's wounds were re-classified 5 months after the Right Lower Extremity Arterial Duplex Ultrasound. The DON stated, .I'm not sure .he is being scheduled for a vascular consult .</p> <p>In summary, Resident #123 who was dependent on staff for repositioning and turning and risk for developing wounds, developed a right heel and right ankle wounds. The wounds were classified as pressure ulcer/injuries for over 5 months before they were classified as vascular/diabetic wounds. The right heel was assessed with s/sx of infection with antibiotics recommended on 8/23/2024. The antibiotic was not started until 8/27/2024.</p> <p>2. Review of the closed medical record revealed Resident #479 was admitted on [DATE], with diagnoses including End Stage Renal Disease, Hemodialysis, Pulmonary Embolism, Heart Failure, Type 2 Diabetes Mellitus, Rheumatoid Arthritis, Morbid Obesity, Polyneuropathy, Unspecified Psychosis, Essential Hypertension, and Sarcoidosis.</p> <p>Review of the Wound Management Detail Report dated 8/31/2023 - 9/11/2023 for the left calf Diabetic Ulcer revealed the following:</p> <p>On 8/31/2023 the left calf Diabetic Ulcer was identified and measured 4.2 cm x 4.6 cm x 0.1 cm with 100% necrotic tissue/eschar. The facility did not identify the ulcer until it was necrotic.</p> <p>On 9/5/2023 the left calf Diabetic Ulcer measured 2.5 cm x 11.6 cm with 70% necrotic tissue and 30% granulation and was declining.</p> <p>On 9/11/2023 the left calf Diabetic Ulcer measured 13.8 cm x 8 cm, had heavy purulent drainage, and was declining.</p> <p>During an interview on 9/5/2024 at 1:50 PM, LPN H was asked if she would expect the diabetic ulcer wound located on Resident #479's left lower leg to be observed and assessed prior to the area having 100% necrotic tissue/eschar, LPN H stated, .I would expect it to be reported before then. When asked if Certified Nursing Assistants (CNAs) report when they see a change in a resident's skin. LPN H stated, I would beg [the CNAs to report]. We are short a lot and the CNAs may be in a rush. I really can't speak as to why it's not seen. It should have been. But that's how it is here .</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439</p> <p>Based on policy review, medical record review, observation, and interview the facility failed to provide care and services consistent with professional standards of practice to appropriately identify pressure ulcers/pressure injuries (PU/PIs), to prevent pressure ulcers/injuries, and promote healing of existing PU/PIs, and failed to prevent the development of additional PU/PIs for 6 of 10 (Residents #27, #78, #151, #171, #478, and #479) sampled residents for pressure ulcers/injury. The facility's failure resulted in Immediate Jeopardy (IJ) when Resident #27 who was at risk of developing PU/PIs, had contractures to upper and lower extremities, and was dependent on staff for preventative interventions, repositioning and turning, developed an open pressure ulcer/injury to the palm of left hand from having long fingernails embedded into the skin and developed a stage 3 PU/PI to the right buttock that was identified as a stage 3, when Resident #78 with a Left Lateral Ankle Stage 4 PU/PI wound that was not consistent with the characteristics of staging, when Resident #151, who was dependent on staff for repositioning and turning and who was at risk for developing PU/PIs, developed pressure wounds to the right foot due to pressure from the foot board, when Resident #171, a resident at risk for developing pressure ulcers, developed a Stage 3 PU/PI to the coccyx that was identified as a stage 3, and when the facility failed to administer prescribed PU/PI treatments for Residents #478 and #479, and when Resident #478's wound was inconsistent with staging.</p> <p>Immediate Jeopardy is 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, or impairment, or death of a resident.</p> <p>The Administrator, and the Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) for F-686 on 9/5/2024 at 11:52 AM, and on 9/5/2024 at 12:24 PM of the amended IJ, in the Chapel.</p> <p>The facility was cited Immediate Jeopardy at F-686 at a scope and severity of J which is Substandard Quality of Care.</p> <p>The IJ was effective from 10/19/2023 and is ongoing.</p> <p>The findings include:</p> <p>1. Review of the National Pressure Injury Advisory Panel 2019 Guidelines, revealed .Skin and soft tissue assessment is the basis of pressure injury prevention and treatment. Skin and tissue assessment is an essential component of any pressure injury risk assessment and should be conducted as soon as possible after admission, as a component of a full risk assessment .Each time the individual's clinical condition changes, a comprehensive skin and tissue assessment should be conducted to identify any alterations to skin characteristics or integrity, and to identify any new pressure injury risk factors . In addition to comprehensive skin assessment, a brief skin assessment of the pressure points should be undertaken during repositioning .Presence of persistent erythema can indicate a need to increase frequency of repositioning. Check pressure points onto which the individual will be repositioned to ensure that the skin and tissue has fully recovered from previous loading .Ongoing skin assessment is necessary to detect early signs of pressure injury .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2. Review of the facility's policy titled, Pressure Injury and Management, revised 8/30/2022, revealed .The facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries. Definitions: 'Pressure Ulcer/Injury' refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. 'Avoidable' means the resident developed a pressure ulcer/injury and that the facility did not do one or more of the following: evaluate the resident's clinical condition and risk factors, define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; monitor and evaluate the impact of the interventions; or revise the interventions as appropriate . Policy Explanation and Compliance Guidelines .2. The facility shall establish and utilize a systemic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate .3. Assessment of Pressure Injury Risk .Licensed nurses will conduct a pressure injury risk assessment .upon admission/re-admission, weekly x four weeks, then quarterly or whenever the resident's condition changes significantly . 4. Interventions for Prevention and to Promote Healing .After completing a thorough assessment/evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management .Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g. moisture management, impaired mobility, nutritional deficit, staging, wound characteristics) .Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to .Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.) .Minimize exposure to moisture and keep skin clean .Provide appropriate, pressure-redistributing mattresses for all residents .Maintain or improve nutrition and hydration status .Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present .Pressure injuries will be differentiated from non-pressure injuries .Treatment decisions will be based on the characteristics of the wound, including the stage, size, exudate (if present), presence of pain, signs of infection, wound bed, wound edge and surrounding tissue characteristics .Interventions will be documented in the care plan and communicated to all relevant staff .Compliance with interventions will be documented in the weekly summary charting .5. Monitoring .The nurse will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of the findings in the medical record .The attending physician (or designee) will be notified of .The presence of a new pressure injury upon identification .The progression towards healing, or lack of healing, of any pressure injuries weekly .Any complications (such as infection, development of a sinus tract, etc.) as needed .A Focused Incident review will be performed on each pressure injury that develops in the facility. Findings will be reported in the monthly QAA [Quality Assessment and Assurance] Committee Meeting .The effectiveness of current preventative and treatment modalities and processes will be discussed in accordance with the QAA Committee Schedule, and as needed when actual or potential problems are identified .6. Modification of Interventions .Interventions on a resident's plan of care will be modified as needed .Changes in resident's degree of risk for developing a pressure injury .New onset or recurrent pressure injury development .Lack of progression towards healing .Resident non-compliance .Changes in the resident's goals .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Skin Assessment, dated 5/2023, revealed .It is our policy to perform a full body assessment as part of or systematic approach to pressure injury prevention and management .Policy Explanation and Compliance Guidelines .1. A skin assessment will be conducted by a licensed or registered nurse upon admission and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury. 2. Procedure .Begin head to toe, thoroughly examining the resident's skin for conditions. Pay close attention to pressure points [can include sacrum, heels, greater trochanter (upper hip area) ischial area (lower hip area), back of the head, ears, shoulders, elbows, inner knees and malleoli (ankle bones)], bony prominences, and underneath medical devices .Remove any special garments or devices .Remove any dressings, using clean technique .and note findings . Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, ad lesions .3. Consider the general status of the resident's skin .Color .Temperature .Moisture status .Skin texture/turgor .Perfusion. 4. Considerations for a resident with darkly pigmented skin .Localized heat .Edema .Bogginess .Induration . Temperature differences of surrounding skin .Skin discoloration. 5. Considerations for a bariatric resident . Perform assessment with at least one other staff member to assist with mobility ad positioning of body parts . Thoroughly inspect each surface skin fold .6. Differentiating the extent of redness .Blanchable erythema (redness) loses its redness when a finger is pressed on the erythema for 3 seconds and released. Blanching is assessed following the removal of the finger .Non-blanchable erythema (redness) persists when touched.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Skin Integrity- Foot Care, reviewed/ revised on 4/1/2024, revealed .Policy: It is the policy of this facility to ensure residents receive proper treatment and care .to maintain mobility and good foot health .Policy Explanation and Compliance Guidelines: 1. This facility will provide foot care and treatment in accordance with professional standards of practice, including the prevention of complications from the resident's medical conditions .The facility will utilize a systematic approach for the prevention and management of foot ulcers, including efforts to identify risk; stabilize, reduce, or remove underlying risk factors; monitor the impact of the interventions; and modify the interventions as appropriate .2. Assessment of risk .Licensed nurses will conduct pressure injury risk assessments and skin assessments in accordance with facility policy for those assessments .The comprehensive assessment process will be utilized for identifying additional risk factors or conditions that increase risk for impaired skin integrity of the foot. Examples include, but are not limited to .diabetes, peripheral vascular disease, peripheral arterial disease, venous insufficiency, peripheral neuropathy, and lack of sensation in the feet .Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after task. 3. Interventions for preventions and to Promote healing .Interventions will be based on specific factors identified in the risk assessment, skin assessment, and assessment of any foot ulcers .Appropriate offloading or orthopedic devise, diabetic shoes, or pressure-relieving devices will be utilized .referrals to podiatrists, vascular or orthopedic surgeons, or wound care physicians will be made when appropriate. The facility will arrange for transportation to and from any appointments .Medical conditions will be managed and interventions will be implemented in accordance with professional standards of practice to prevent complications from medical conditions .Evidence-based treatments will be provided for all residents who have a foot ulcer .Pressure injuries will be differentiated from non-pressure ulcers . 4. Monitoring .The attending physician will assume responsibility for overall care and treatment of the resident's medical conditions .RNs [Registered Nurses] and LPNs [Licensed Practical Nurses] will participate in the management of medical conditions by following physician orders, assessment of residents, and reporting changes in condition .Interventions will be modified in a resident's plan of care as needed. Considerations for needed modifications include .Changes in medical condition or degree of risk for developing foot ulcers .New onset or recurrent foot ulcer .lack of progression towards healing .Resident non-compliance .Changes in the resident's goals and preferences. 6 .The facility will follow proper infection prevention practices for foot care equipment/devices, including but not limited to nail clippers .reusable medical devices .must be cleaned and reprocessed .</p> <p>3. The facility's Pressure Injury Staging and Care Plan Consideration and Pressure Injury Management Guidelines documents (from The Named Company dated 2019) were provided to the survey team on 9/4/2024, when the facility was asked for the source used by the facility to identify and stage pressure ulcers/injuries. The documents are as follows:</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>a. Review of the facility's Pressure Injury Staging and Care Plan Consideration document revealed, .Stage 1 Pressure Injury: Non-blanchable erythema of intact skin .Intact skin with a localized area of non-blanchable erythema [a skin discoloration that doesn't run white when pressed], which may appear differently in darkly pigmented skin Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis [middle layer of skin] .The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue [healing process for deep pressure ulcers], slough [dead tissue], and eschar [dead dark tissue] are not present. These injuries commonly result from adverse microclimate [temperature, humidity airflow near the skin] and shear in the skin over the pelvis and shear [pressure and friction exerted] in the heel . Stage 3 Pressure Injury . Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible .Undermining and tunneling [tunneling and separation in a wound that occurs under the skin] may occur .If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury .Stage 4 Pressure Injury .Full-thickness skin and tissue loss with exposed or directly palpable fascia [tissue, tendons, etc. that are exposed and can be felt in a stage 4 pressure ulcer/injury], muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible, Epibole (rolled edges), undermining and/or tunneling often occur .If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury . Unstageable Pressure Injury: Obscured Full-thickness skin and tissue loss .in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar .Deep Tissue Pressure Injury [DTPI]: .Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister .This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface .Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>b. Review of the facility's Pressure Injury Management Guidelines document revealed, .Stage 1 .Off Load . Manage Moisture Cover/Protect .Strategies to Protect: Choose Moisture Barrier to match type and level of incontinence. Assess repositioning interval. Assess support surfaces. Assess wheel chair positioning .Stage 2 Partial Thickness .Off Load .Manage Exudate Cover/Protect .Cleanse with normal saline or Wound Cleanser. Light Exudate: Apply Hydrogel, Hydrogel Ag [silver], Honey Hydrogel, Xeroform or Petrolatum Gauze. Change Daily. Minimal/Moderate Exudate: Apply Hydrocolloid Dressing. Change Q3D [every 3 days] . Stage 3 Full Thickness . Off Load .Manage Exudate Fill cavity Cover/Protect .Cleanse with normal saline or Wound Cleanser. Light Exudate: Apply Hydrogel, Hydrogel Ag, Honey Hydrogel or Collagen. Moderate Exudate: Apply Collagen, Calcium Alginate, Honey Alginate or Super Absorbent Dressing. Heavy Exudate: Apply Calcium Alginate, Honey Alginate or Super Absorbent Dressing. Change QD [every day] or QOD [every other day] .Stage 4 Full Thickness .Off Load .Manage Exudate . Debride if needed .Fill cavity Cover/Protect . Cleanse with normal saline or Wound Cleanser. Light Exudate: Apply Hydrogel, Hydrogel Ag, Honey Hydrogel or Collagen. Moderate Exudate: Apply Collagen, Calcium Alginate, Honey Alginate or Super Absorbent Dressing. Heavy Exudate: Apply Calcium Alginate, Honey Alginate or Super Absorbent Dressing. Change QD or QOD .Unstageable 100 % [percent] Eschar Full Thickness .Off Load . Manage Exudate . Debride . Fill Cavity .Cover/Protect . Cleanse with normal saline or Wound Cleanser. Chose a debridement: Autolytic, enzymatic or sharp debridement. Light Exudate: Apply Hydrogel, Hydrogel Ag, Honey Hydrogel dressing. Moderate Exudate: Apply Collagen, Calcium Alginate, Honey Alginate or Super Absorbent Dressing. Heavy Exudate: Apply Calcium Alginate, Honey Alginate or Super Absorbent, Change Dressing QD or QOD . Unstageable .Off Load .Keep Dry .Cover/Protect .Assess Support Surfaces .Decrease Friction/Shear .Stable Eschar: Keep area dry. Keep area intact. Assess wheelchair positioning and seating. Stable Eschar on heels: (dry, no erythema, no exudate, fluctuance [Sign of pus that has accumulated beneath the surface of the skin])- area does not need to be debrided. Paint with skin prep or betadine. Off load heels. No shoes . Deep Tissue Injury [DTI] .Off Load .Keep Dry .Cover/Protect .Assess Support Surfaces .Decrease Friction/Shear . Strategies to protect: DTI on heels: Suspend heels with pillows, specialty cushions, boots. DTI sacral/gluteal: Use moisture barrier to match type and amount of incontinence. Assess repositioning interval. Assess support surfaces. Assess wheelchair positioning and seating .Medical Device Related Pressure Injuries .Pressure injuries that result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant ulcer generally conforms to the pattern or shape of the device. Should be staged to the most severe tissue damaged depth .Off Load .Manage Exudate .Debride if needed .Fill cavity . Cover/Protect .Removal, padding or repositioning of device causing injury is of utmost importance to allow and/or prevention. Residents with any type of medical device in place should be assessed at least twice a day for possible skin injury.</p> <p>4. Review of medical record revealed Resident #27 was admitted on [DATE], with diagnoses including Cerebral Infarction, Hemiplegia, Diabetes, Contracture, Dysphagia, Dementia and Aphasia.</p> <p>Review of the Braden Scale assessment completed on 12/30/2022 revealed Resident #27 was at high risk of developing a pressure ulcer. The facility failed to provide Resident #27's Braden Scale Assessment since the admission assessment on 12/30/2022 after requesting.</p> <p>Review of Resident #27's care plan revealed .Approach Start Date 4/20/2023 CONTRACTURES: The resident has contractures of the LUE [left upper extremity], bilateral hands). Provide skin care to keep clean and prevent skin breakdown .</p> <p>Review of Resident #27's care plan revealed .Approach date 11/22/2023 . Resident is at risk for skin breakdown R/T [related to] immobility .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #27 was rarely/never understood with cognitive skills for daily decision making severely impaired. The resident did not have a Brief Interview for Mental Status (BIMS) score. Further review revealed Resident #27 had impaired Range of motion (ROM) to upper left side extremity and a ROM impairment to both lower extremities. Resident #27 was dependent on staff for all activities of daily living (ADL's).</p> <p>Review of Resident #27's Medication Administration Record (MAR) dated 8/1/2024 through 8/31/2024 revealed:</p> <p>Cleanse area to palm of left hand with wound cleanser, pat dry, apply calcium alginate with a dry 4 x (by) 4, on Monday, Wednesday, and Friday.</p> <p>Cleanse stage 3 (III) to right buttock with wound cleanser pat dry, apply silver alginate and cover with border foam 3 times weekly and as needed.</p> <p>Review of Resident #27's care plan revealed .Approach Start Date: 8/6/2024 Rolled wash cloth inside left hand .</p> <p>Review of Resident #27's Wound Event Note dated 8/7/2024, revealed laceration to palm of left hand, caused by fingernails embedded into left hand, with measurements, in centimeters (cm) by (x) length x width x depth (L x W x D), of 2.2 cm x 2.0 cm x 0.2 cm.</p> <p>The facility failed to provide signed physician orders for the pressure ulcer/injury treatment to Resident #27's left hand palm.</p> <p>Review of Resident #27's care plan revealed .Approach Start Date: 8/7/2024 Resident has skin tears or cuts palm of left hand .Record location, size (length, width, depth), color, surrounding skin, presence/absence of drainage/pain/signs of healing every week .Treat area per MD [Medical Doctor] orders .</p> <p>Review of Resident #27's progress note dated 8/13/2024, revealed .laceration measures 0.2 cm x 0.2 cm x 0.1 cm left palm .</p> <p>Review of the INTEGRATED WOUND CARE Follow-up Progress Note dated 8/16/2024, revealed a stage 3 pressure injury/ulcer was identified on Resident #27's right buttock as a pressure injury with moderate serosanguinous exudate and tissue type documented with 100% granulation. The wound measured 1.1 cm x 0.9 cm x 0.3 cm.</p> <p>Review of the medical record revealed Resident #27's stage 3 to right buttock pressure injury was identified on 8/16/2024 with measurements of 1.1 cm x 0.9 cm x 0.3 cm.</p> <p>Review of Resident #27's MARS dated 8/1/2024 -8/31/2024, revealed no wound treatment documentation for right buttock stage 3 pressure injury on 8/16/2024.</p> <p>The facility failed to provide signed physician orders for treatment of Resident #27's stage 3 pressure injury.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #27's care plan revealed .Approach Start [NO DATE] Resident with stage 3 to right buttock .provide treatments as ordered .assess wounds and skin weekly for changes .keep clean and dry as possible .Minimize skin exposure to moisture .keep linen clean and dry and wrinkle free . The care plan was not revised/updated to reflect the date the Stage 3 was identified.</p> <p>Observation on 8/19/2024 at 9:30 AM and 2:45 PM, and on 8/20/2024 at 8:09 AM and 2:23 PM, revealed Resident #27's fingernails appeared trimmed with jagged edges, bilateral hands without hand rolls, and with a foul odor. The resident's legs were observed to be contracted. The facility failed to follow the care plan for bilateral hand rolls for Resident #27.</p> <p>During an interview on 8/20/2024 at 2:30 PM, CNA O was asked how many staff are supposed to turn and reposition Resident #27. CNA O stated, We try to use 2 staff to turn and repo [reposition]. CNA O was asked if she smelled an odor from Resident #27's hands. CNA O stated, They are sweaty and needs cleaning I will get someone to help me wash them. CNA O was asked when Resident #27's hands are washed. CNA O states, She is bathed daily, but we ask the nurse to help open her hands at times . CNA O was asked what she would do if she observed an injury or a wound on a resident. CNA O stated, I would need to tell my nurse. CNA O was asked if Resident #27 was supposed to have anything in her hands. CNA O stated, I think so, I will get some washcloths . CNA O was asked why she didn't have hand rolls in her hands. CNA O stated, .guess we forgot .we should have had them there in her hands when we came on shift this morning . CNA O was asked how often Resident #27's nails are trimmed. CNA O stated, I don't know the nurse takes care of that . CNA O was asked if Resident #27 can open her hands on her own. CNA O stated, .no she cannot do anything she had a stroke .we do all her care, she's totally dependent on staff .</p> <p>During an interview on 8/20/2024 at 3:15 PM, LPN N was asked who trims Resident #27's nails. LPN N stated, The CNA trims her nails weekly . LPN was asked who cleans her hands. LPN N stated, .the CNA cleans her hands daily . LPN N was asked if Resident #27 had a wound inside her left hand. LPN N stated, I think she does but the wound nurse takes care of the wounds . LPN N was asked would Resident #27 have interventions in place for her hand contractures. LPN N stated, She needs hand rolls for that .</p> <p>Observation on 8/20/2024 at 3:45 PM, revealed Resident #27 did not have hand rolls in her hands in accordance with the resident's care plan. The resident's legs were observed to be contracted.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation and interview in Resident's room on 8/21/2024 at 10:30 AM, with LPN A revealed Resident #27's bilateral hands did not have hand rolls. LPN A was asked when Resident #27 should have hand rolls. LPN A stated, She should have hand rolls each shift, I will do that now. LPN A opened Resident #27's left contracted hand, removed the dressing from her left palmed hand. Observation of Resident #27's palm of left-hand revealed a round open wound. The round edge of the wound appeared white with a moist edge surrounding the wound. The wound bed was red. The dressing had light brown drainage, with a slight odor. The wound measured (L length x [by] width x Depth) 2.0 cm x 2.0 cm x 0.2 cm. LPN A was asked what caused the wound and what stage was the wound. LPN A stated, I originally found the wound on 8/7 [2024] during her weekly skin assessment. My wound event note was documented as a laceration .the injury was caused by her fingernails embedded into her left palm of her hand. LPN A was asked if the wound was caused by pressure to the left palm from her nails embedded into her hand. LPN A stated, Yes, it was . LPN A was asked if the laceration she documented was actually a pressure injury. LPN A stated, I can't say . LPN A was asked if she can stage a wound. LPN A stated .Yes I am certified, but the Wound Nurse Practitioner stages the wounds . LPN A was asked if the wound should be staged as a pressure injury. LPN A stated, . the nails were pressed into her skin by her contracted hand, and pressure was applied, I would say it could be a pressure injury . LPN A was asked who trims her fingernails and how often are they trimmed. LPN A stated, The charge nurse usually trims them .I can't say when the last time they were trimmed . LPN A was asked how long her fingernails were on the day the wound was found. LPN A stated, Her nails were very long .that's why they cut into her hand and why I documented a laceration . LPN A was asked how often Resident #27's hands are cleaned. LPN A stated, Staff should clean her hands everyday but the nurses may have to assist with opening her hands. LPN A was asked if Resident #27 can open her hands or position herself in bed. LPN A stated, No she's total dependence [on staff] with her care. LPN A was asked what interventions are in place for Resident #27's hand contractures. LPN A stated, She is supposed to have a hand roll or rolled wash cloths in her hands. LPN A was asked if Resident #27's hand had a foul odor and why she doesn't have hand rolls in place. LPN A stated, Yes, her hands have an odor and need to be cleaned .she needs hand rolls in her hands as well . LPN A was asked how often the dressing is changed. LPN A stated, 3 times a week. LPN A was asked why the laceration was changed to a skin tear on 8/23/2024. LPN A stated .I probably would not have changed the wound to a skin tear, but the wound NP documented that . LPN A was asked if the wound could have been prevented. LPN A stated, I believe so. LPN A was asked if the resident's left palm wound was larger than the last measurement. LPN A stated .I believe so, it's almost the same size as the day it was initially found . The resident's legs were observed to be contracted.</p> <p>The 8/21/2024 measurements were not documented in the medical record, and the 8/21/2024 measurements had increased in size from the 8/13/2024 measurements.</p> <p>Observation on 8/22/2024 at 7:30 AM, revealed Resident #27 did not have hand rolls in her hands in accordance with the care plan.</p> <p>Observation and interview in the resident's room on 8/22/2024 at 10:30 AM, revealed LPN C described Resident #27's right buttock as a stage 3 pressure injury. LPN C stated, .the wound appears as a full thickness tissue loss with the wound bed red with granulation tissue measuring 0.5 cm x 0.5 cm x 0.3 cm. LPN C was asked when the wound was found and at what stage was the wound when it was first documented. LPN C stated, The right buttock [pressure ulcer/injury] was found on 8/16/2024 at a Stage 3. LPN C was asked how Resident #27 developed a wound at a stage 3. LPN stated, .her comorbidities . LPN C was asked if a wound should initially start at a stage 3. LPN C stated, No, it should not start as a stage 3 pressure injury.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #27's progress note dated 8/23/2024, revealed .skin tear to left hand measures 0.4 cm x 0.4 cmx 0.1 cm .</p> <p>Resident #27's left palm pressure injury healed on 8/24/2024.</p> <p>Review of the INTEGRATED WOUND CARE Follow-up Progress Note dated 8/23/2024, revealed Resident #27's .pressure ulcer stage 3 to right buttock was .documented as a pressure injury with moderate serosanguinous exudate and tissue type with 50% granulation and 50% dermis. The wound measured 0.5 cm x 0.5 cm x 0.3 cm .</p> <p>Review of Resident #27's shower/bath sheets dated 8/2/2024, 8/6/2024, 8/9/2024, 8/13/2024 revealed no documentation the resident had any skin integrity issues or open area to the right buttock.</p> <p>Review of the INTEGRATED WOUND CARE Follow-up Progress Note dated 8/26/2024, revealed Resident #27's pressure ulcer stage 3 to the right buttock was documented as a pressure injury with no exudate, with tissue type 100% epithelial, and measured 0.5 cm x 0.5 cm x 0.3 cm.</p> <p>The facility was asked for signed MD orders on 8/27/2024. The facility did not provide requested signed MD on 8/27/2024. The facility was asked for signed MD orders on 8/28/2024. The facility did not provide requested signed MD orders on 8/28/2024. The facility provided signed MD orders on 8/29/2024, but the orders did not include Resident #27's treatments to pressure injury to palm of left hand or stage 3 right buttock.</p> <p>During an interview on 8/29/2024 at 2:30 PM, the DON was asked if the Medical Regimen Review Report dated 8/1/2024 through 8/28/2024 included the complete signed physician orders August 2024 for Resident #27. The DON stated Yes. The DON was asked if she can see treatment orders on the report. The DON stated No, but I will check on that . The DON was asked if the treatment orders should be signed by the physician. The DON stated Yes. The DON was asked if a treatment isn't signed on the MAR or Treatment Administration Record (TAR), was the wound treatment completed. The DON stated, .if it's not documented it's not completed.</p> <p>Review of the INTEGRATED WOUND CARE Follow-up Progress Note dated 9/2/2024, revealed .Pressure ulcer Buttock right .Resolved 9/2/2024 .PLAN .MASD [moisture- associated skin damage] right Buttock . Cleanse with wound cleanser, pat dry. Apply collagen, border gauze. QD [every day]/ [and] prn [as needed] .</p> <p>The facility failed to reassess and implement interventions for the change in wound classification to a MASD.</p> <p>Review Resident #27's progress notes dated 9/2/2024, revealed .Resident was seen by wound NP today per her observation stage 3 to right buttock .resolved .</p> <p>During an interview on 9/4/2024 at 9:30 AM, the Wound Nurse Practitioner (NP) was asked how a wound in the palm of a contracted left hand caused by long fingernails, could be identified initially as a laceration on 8/7/2024, then on 8/23/2024 be changed to a skin tear, and not be identified as a pressure injury to the palm of her left han [TRUNCATED]</p>		

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NAME OF PROVIDER OR SUPPLIER Midtown Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 141 N McLean Blvd Memphis, TN 38104	
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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** 33379</p> <p>Based on policy review, medical record review, observation and interview the facility failed to provide appropriate care and services for residents with an indwelling catheter (a tube in the bladder that drains urine) for 2 of 4 (Resident #71 and #91) sampled residents reviewed for indwelling catheters.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Indwelling Catheter and Removal, dated 3/15/2023, revealed .Indwelling urinary catheters are catheters that remain in the bladder to assist with urinary elimination .increase the risk of urinary tract infections .If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures .</p> <p>Review of the facility policy titled, Catheter Care, dated 2/20/2024, revealed .It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use .Catheter care will be performed every shift and as needed by nursing personnel .</p> <p>2. Review of the Hospital Progress Note for Resident #71 dated 11/10/2022, prior to admission to the nursing home facility, revealed .Chief Complaint .abd [abdominal] pain and unable to urinate. Abd [abdomen] firm and distended on arrival. Pt [Patient] unable to state when he last urinated .Foley catheter was placed . impression .Acute urinary retention due to bladder outlet obstruction .Acute renal failure .UTI [urinary tract infection] .</p> <p>Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Atrial Fibrillation, Retention of Urine, Dysuria, Diabetes, Congestive Heart failure and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the January 2023 Physician's Orders for Resident #71 revealed, .Provide [named indwelling urinary catheter] .care with soap and water every shift and PRN [as needed] .Order Date .11/14/2022 . Change [named indwelling urinary catheter] .bag Q [every] 2 weeks on the first and 15th of every month .</p> <p>Review of the October 2023 Medication Administration Record (MAR) revealed there was no documentation Resident #71's catheter bag was changed in the month of October.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #71 was cognitively intact and had an indwelling urinary catheter.</p> <p>Review of the November 2023 MAR revealed there was no documentation Resident #71's catheter bag was changed in the month of November.</p> <p>(continued on next page)</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>Review of the December 2023 MAR revealed there was no documentation Resident #71's catheter bag was changed in the month of December.</p> <p>Review of the medical regimen review report dated 7/1/2023 - 12/31/2023, revealed .Change .[named indwelling urinary catheter] Bag every 2 weeks on night shift and as needed .Start Date 09/18/2023 .</p> <p>The facility was unable to provide documentation that Resident #71's catheter bag was changed every 2 weeks as ordered for the months of October, November and December of 2023.</p> <p>The facility failed to provide catheter care and ensure resident #71's catheter bag was changed in accordance with the physician's orders and their policy to prevent potential catheter related problems such as UTIs.</p> <p>Review of the progress notes revealed, .1/23/2024 .The nurse assessed the resident [#71] having dark red blood and sediments in urine in his 16 Fr [French] . [named indwelling urinary catheter] .BP [blood pressure] 101/67 P [pulse] 105 T [temperature] 101.9. The resident verbally states that his catheter has not pulled/tugged .The nurse contacted .MD [Medical Doctor] gave orders to collect UA [urinalysis], & [and] to create orders for lab [laboratory] to draw CBC [Complete Blood Count], BMP [Basic Metabolic Profile]. The nurse collected urine and the urine had a foul strong odor .The nurse performed catheter care and changed the resident's foley bag .</p> <p>Review of the URINE CULTURE dated 1/23/2024, revealed > [greater than] 100,000 cfu [colony forming unit]/mL [milliliter] Multiple bacterial morphotypes [group of organisms in urinary sediment that can be a valuable tool for diagnosis] present; no predominant pathogen .</p> <p>Review of the January 2024 MAR revealed Resident #71's catheter bag was not signed as being changed till the resident complained of pain on 1/25/2024.</p> <p>Review of the progress note revealed, .1/25/2024 .Resident [#71] complained of pain to lower abdomen and perineal area. He has decreased urine output and c/o [complaint of] pain 5/10. Attempted to remove foley and reinsert and resident refused. Patient stated he wanted to be transferred to the hospital .</p> <p>Review of the progress notes revealed, .1/25/2024 .c/o of bladder pain and no urinary output .head to toe assessment completed with bladder distention noted. resident [#71] refused to allow this nurse to change foley out did allow to flush with 60cc of normal saline. NP [Nurse Practitioner] was notified and gave new order for lab and bladder scan but resident refused and asked to be transported to hospital .resident . transferred to [Named Hospital] .</p> <p>Review of the Hospital ED (Emergency Department) records dated 1/25/2024 and 1/26/2024 revealed Resident #71 presented to the ED and was discharged back to the nursing facility on 1/26/2024.</p> <p>(continued on next page)</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>Review of ED Physician Documentation dated 1/25/2024, revealed .Presented today with abdominal distention, and with a malfunctioning Foley which was not draining. Urology was consulted, and they removed the Foley. It was apparently encrusted and difficult to remove, somewhat traumatic .Foley has been replaced .shows mild leukocytosis [a high white blood cell count that can be caused from infections, inflammation, injury or immune disorder] .Follow up with Urology .Take the antibiotic .for urinary tract infection .The patient presents with urinary retention .from the nursing home .States he has had his foley in place for over a year w/o [without] it being changed. He is coming from a nursing home and nursing home reports it hasn't been exchanged since November 2022. Attempted to deflate balloon, which only removed 3L [liter] of a yellow-brown liquid. When attempting to remove unable to withdraw and patient is in extreme pain. Cut the catheter balloon port off w/o further drainage or deflation .Spoke with urology .asked for patient to be able to urinate prior to discharge. If patient is unable to do so, advised giving him a couple of hours before replacing the foley .Unable to urinate will require foley placement prior to discharge .patient is tachycardic and diaphoretic. Likely due to bladder distention with unable to void .Impression and Plan . Condition: Stable .was given the following educational materials: FOLEY CATHETER CARE, URINARY RETENTION .</p> <p>Review of the 1/26/2024 ED Discharge Instructions revealed, .Be sure to follow up with your regular physician or specialist as instructed at discharge as this is the best way to ensure that you receive the very best of care .</p> <p>Review of the progress note revealed, .1/26/2024 .Resident [#71] arrived via [by way of] stretcher x [times] 2 assist .16 Fr .catheter .Dark red urine, medium amount of urine in bag .1/29/2024 .Resident continues ABT [antibiotic] therapy for UTI .</p> <p>Review of the progress notes revealed, .3/5/2024 .Attempted to change resident's foley catheter and resident refused, stating You are not changing my catheter, I only want the bag changed and I told you that.Foley bag changed, resident tolerated well .</p> <p>Review of the March 2024 MAR revealed Resident #71's catheter bag was not signed as being changed as ordered for the month of March.</p> <p>Review of the lab results dated 4/15/2024, revealed .URINALYSIS .NITRITE POSITIVE .LEUKOCYTES 3+ [plus] RBC [red blood cells] 0-2 .WBC [white blood cells] 20-30 .BACTERIA MANY .URINE CULTURE .> [greater than] 100,000 CFU [colony-forming unit] [a count to measure the number of bacteria in a urine sample] .ML [milliliter] PROVIDENCIA RETTGERI [is a bacteria primarily associated with complicated urinary tract infections from patients that have long term catheter] .</p> <p>Review of the progress notes revealed, . 4/27/2024 .Resident completes Macrobid therapy for UTI .</p> <p>Review of the progress notes revealed, . 4/29/2024 .nurse spoke to resident and asked resident why he refuses to let staff provide foley catheter exchanges. Resident stated, No, I am not going to let them touch my foley, and you all can just get ready to send me to the hospital whenever it needs to be changed.</p> <p>Review of the April 2024, May 2024, June 2024, and July 2024 MARs revealed there was no documentation Resident #71's catheter bag was changed each month as ordered.</p> <p>(continued on next page)</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>Review of the August 2024 Physician Orders revealed, .Change [named indwelling urinary catheter] .Bag every 2 weeks on night shift and as needed .Start Date 09/18/2023 .</p> <p>Observation in the resident's room on 8/27/2024 at 3:04 PM, revealed Resident #71 dressed, lying in the bed with an indwelling urinary catheter hanging on the right side of the bed, a privacy bag covering the drainage bag.</p> <p>During an interview on 8/29/2024 at 2:10 PM, Licensed Practical Nurse (LPN) I confirmed she took care of Resident #71, he was compliant with catheter care and let staff change his catheter bag.</p> <p>Review of the Urology Consult dated 8/30/2024, revealed .I explained to the patient today .that it [indwelling catheter] definitely needs to be changed every month .Infection in a patient with a catheter, is only when the patient has bacteria in the urine and they are having symptoms or very foul-smelling urine .</p> <p>During a telephone interview on 9/3/2024 at 10:05 AM, Previous Nurse Practitioner (NP) R was asked about Resident #71's catheter and how often catheters should be changed. NP R stated, .didn't [facility] share with me any policies and one of those was catheter change .I was hoping it was not true .about not being changed in a year .catheter should be changed out every 3 months .but has to be done routine and catheter care daily .that should come with standard of care with the facility .a part of the protocol that is missing .</p> <p>During an interview on 9/4/2024 at 9:01 AM, the Director of Nursing (DON) confirmed physician orders should be followed, Resident #71's catheter bag should have been changed every 2 weeks, and there should be no blanks left on the MAR, if he had refused, should be signed and clicked refused.</p> <p>During an interview on 9/4/2024 at 9:36 AM, the Administrator confirmed Physician orders should be followed and stated, .we don't change the catheter .he [Referring to Resident #71] goes to the ER [emergency room] or urologist, what we do is change the catheter bag . The Administrator confirmed catheter care should be provide, there should be no blanks on the MAR and if the resident refused it should have been documented.</p> <p>During a telephone interview on 9/4/2024 at 3:59 PM, Previously Employed NP Q confirmed she provided care to Resident #71 and was asked how often catheters should be changed. NP Q stated, .I don't know what the policy was at that time .asked numerous times .when I did ask people no one could give me an answer .I asked the physician .administration and nurse's staff .standard practice every month . NP Q confirmed the catheter bags should be changed every 2 weeks and not changing the bag every 2 weeks could cause a urinary tract infection and stated, .due to the sediment build up . NP Q was asked do you feel like residents are receiving quality care at the facility. NP Q stated, No.</p> <p>During a telephone interview on 9/5/2024 at 8:35 AM, LPN M confirmed Resident #71 allowed staff to perform catheter care and change out the catheter bag, but he wanted to be sent to the hospital to have the catheter exchanged.</p> <p>During an interview on 9/5/2024 at 4:01 PM, the DON confirmed that she was unable to provide the UA that was ordered on 1/23/2024.</p> <p>(continued on next page)</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>During a telephone interview on 9/5/2024 at 4:32 PM, the Medical Director confirmed he provided Resident #71's care. The Medical Director was asked how often catheters should be changed. The Medical Director stated, . I've been Director here .just over a year .my protocol case to case . change every month . The Medical Director confirmed catheter bags should be changed every 2 weeks and stated, .that is the protocol to avoid uti . The Medical Director was asked should physician orders be followed. The Medical Director stated, Definitely.</p> <p>During an interview on 9/5/2024 at 6:09 PM, the DON was asked did the facility do an assessment or put anything in place for why Resident #71 didn't want the staff to change out his catheter. The DON stated, .we sent him to urologist .and try to encourage him .</p> <p>3. Review of the medical record revealed Resident #91 was admitted to the facility on [DATE], with diagnoses including Dysphagia, Malignant Neoplasm of the Breast and Colon, History of Breast Cancer, Need Assistance with Personal Care, Diabetes, Acute Kidney Failure, Severe Protein Malnutrition, Pressure Ulcer of Left and Right Buttocks Stage 3, and Obstructive Reflux Uropathy.</p> <p>Review of the admission MDS dated [DATE] revealed Resident #91 had a BIMS of 4, which indicated severe cognitive impairment, incontinent of bowel, the use of an indwelling urinary catheter, and the use of a feeding tube.</p> <p>Review of the Care Plan revised 7/30/2024, revealed .Problem Start Date .7/3/2024 .Indwelling Catheter . Resident requires an indwelling urinary catheter r/t [related to] obstruction .Provide catheter care .</p> <p>Review of a Physician Order dated 7/3/2024 to 7/29/2024, revealed Foley 16 FR with 10 cc balloon to bedside straight drainage for diagnosis / Hx [history of] need .every shift .</p> <p>Review of the facility's Treatment Administration Record (TAR) for July 2024 revealed staff documented the use of a 16 Fr 10cc [NAME] indwelling catheter every shift from 7/3/2024 to 7/16/2024.</p> <p>Review of the medical record revealed no order for indwelling catheter care for the use of an indwelling urinary catheter for August 2024.</p> <p>Review of the August 2024 TAR revealed Resident #91 had no order for urinary catheter care.</p> <p>Review of a Physician Progress Note dated 8/9/2024 revealed, .Foley catheter with sediment looking urine .</p> <p>Observations in the resident's room on 8/19/2024 at 10:56 AM and 3:01 PM, and 8/20/2024 at 8:25 AM, revealed an indwelling urinary catheter tube with cloudy yellow urine in tubing, catheter bag elevated and contained in a privacy bag.</p> <p>Observation in the resident's room on 8/21/2024 at 8:44 AM and 9:27 AM, revealed an indwelling urinary catheter bag contained in a privacy bag and elevated with clear yellow urine in tubing.</p> <p>Observation in the resident's room on 8/26/2024 at 11:04 AM and 2:26 PM, revealed an indwelling urinary catheter bag contained in a privacy bag and elevated at bedside.</p> <p>(continued on next page)</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>Observation in the resident's room on 8/28/2024 at 11:29 AM and 3:32 PM, and 8/29/2024 at 11:33 AM, revealed an indwelling urinary catheter bag contained in a privacy bag and elevated with yellow urine in the tubing.</p> <p>During an interview on 8/29/2024 at 2:23 PM, the DON was asked if a resident has an indwelling urinary catheter should they have written physician orders for the use. The DON confirmed that residents should have physician orders for the use of an indwelling urinary catheter. The DON confirmed that residents should receive catheter care at least every shift. The DON confirmed that Resident #91 was admitted with an indwelling urinary catheter.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure care and services were provided for 1 of 4 (Resident #91) residents reviewed for the use of a Percutaneous Endoscopic Gastrostomy (PEG) tube (a PEG tube is inserted into the stomach to give medications and food supplements).</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled Care and Treatment of Feeding Tube revised 5/31/2023, revealed .It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible .Feeding tubes will be utilized according to physician orders .The resident's plan of care will address the use of feeding tube, including strategies to prevent complications .Examination and cleaning of the insertion site in order to identify, lessen, or resolve possible skin irritation and local infection .</p> <p>2. Review of the medical record revealed Resident #91 was admitted to the facility on [DATE], with diagnoses including Dysphagia, Malignant Neoplasm of the Breast and Colon, History of Breast Cancer, Needs Assistance with Personal Care, Diabetes, Acute Kidney Failure, Severe Protein Malnutrition, Pressure Ulcer of Left and Right Buttocks Stage 3 and Obstructive Reflux Uropathy.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #91 scored a 4 on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. Resident #91 has a PEG tube for medications and feeding.</p> <p>Review of the Medical Regimen Review Report revealed, . Start date .6/14/2024 .Enteral Feeding (Bolus) . Administer ONE carton Nepro Carb Steady [enteral feeding supplement] via [by way of] PEG at Rate q [every] 6 hrs [hours] to provide total of 948 ml [milliliters] .</p> <p>Review of the Care plan last reviewed and revised 7/3/2024, revealed, .Problem Start Date .7/3/2024 . Feeding Tube .requires feeding tube R/T [related to] dysphagia .Provide peg tube care as ordered .</p> <p>Review of the June 2024 and July1-16, 2024 Treatment Administration Record (TAR), revealed no documentation Resident #91 received PEG site care.</p> <p>Observation in the resident's room on 8/19/24 at 10:56 AM, 3:01 PM, and on 8/20/2024 at 8:25 AM, revealed PEG tube feeding Nephro infusing at 65ml/hr and auto flush at 40ml/hr.</p> <p>Observation in the resident's room on 8/26/24 at 2:16 PM, revealed enteral feeding supplement and syringe on the bedside table labeled and dated 8/26/2024.</p> <p>Observations in the resident's room on 8/28/24 at 8:00 AM, 11:29 AM, and 3:32 PM, revealed PEG feeding syringe and enteral feeding supplement on the bedside table labeled and dated 8/28/2024.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation in the resident's room on 8/29/24 at 11:33 AM, revealed PEG feeding syringe and enteral feeding supplement on the over the bed table labeled and dated.</p> <p>The facility failed to ensure care and services for the use of a PEG tube for Resident #91 when peg site care was not performed.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50408</p> <p>Based on job description, facility employee file, medical record review, and interview, the facility failed to ensure the licensed practical nurses (LPN) who performed wound care had the competencies and skill sets necessary to perform the care and services for pressure ulcers for 3 of 3 LPNs (LPN A, LPN B, and LPN C) who performed wound care for pressure ulcers for 7 of 10 sampled (Resident #27, #78, #123, #151, #171, #478, and #479) residents who received wound care for pressure ulcers.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the Treatment Nurse Job Description updated 12/2018, revealed .Provide nursing care to residents as prescribed by the physician and in accordance with standards of nursing practice and regulations .assess and document resident progress in the medial record. Perform all preventative skin care, dressing changes and wound care. Monitor turning and positioning of residents. Monitor the treatment of decubitus ulcers with appropriate documentation and communication to the physician .notify physician of new skin problems, changes of condition .Communicate pertinent information about resident condition and progress . Review of the Clean Wound Dressing Change competency form for LPN A revealed the skills documentation section was incomplete. The competency form was not dated or signed by a Reviewer. <p>Review of the Clean Wound Dressing Change competency form for LPN C revealed the skills documentation section was incomplete. The competency form was not dated or signed by a Reviewer.</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #27 was admitted on [DATE], with diagnoses including Hemiplegia, Diabetes, Contracture, Dysphagia, Cerebral Infarction, Atrial Fibrillation, and Gastrostomy Status. <p>Resident #27 developed a facility acquired pressure ulcer to the hand due to the Resident's long fingernails being embedded into the Resident's skin.</p> <p>A Stage 3 facility acquired pressure ulcer to the Resident's right buttock was discovered by staff on 8/16/2024. There was no documentation the Resident had a Stage 3 pressure ulcer to the right buttock prior to 8/16/2024.</p> <p>There were no signed physician's orders for treatments to the Resident's hand and buttocks pressure ulcers. LPN C was Resident #27's wound/treatment nurse.</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #78 was admitted to the facility on [DATE], with diagnosis including Cerebral Infarction with Hemiplegia, Dysphagia, Diabetes, Seizures, Major Depressive Disorder, Cardiac Pacemaker, and Gastrostomy. <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #78 developed a facility acquired pressure ulcer to Left Lateral Ankle area which was identified as a Stage 4 pressure ulcer. LPN B inconsistently assessed the staging of the pressure ulcer. LPN B was Resident' 78's wound/treatment nurse. LPN B had competencies and skills for providing and assessing wounds.</p> <p>5. Review of the medical record revealed Resident #123 was admitted on [DATE], with diagnoses including Peripheral Vascular, Diabetes, Neuropathy, and Chronic Kidney Disease.</p> <p>Resident #123 developed a vascular wound to the right heel on 7/30/2024. On 8/26/2024, LPN C documented the wound drainage with a foul order at which time the NP ordered antibiotics. There was no documentation LPN C had identified the worsening of the wound prior to 8/26/2024. LPN C was Resident #123's wound/treatment nurse.</p> <p>6. Review of the medical record revealed Resident #151 was admitted to the facility on [DATE], with diagnoses including Benign Prostatic Hypertrophy, Difficulty Walking, Anxiety, Spinal Stenosis, Tobacco Use, Moderate Protein Calorie Malnutrition, Polyneuropathy and Stage 3 Pressure Ulcer.</p> <p>Resident #151 developed a facility acquired pressure ulcer to the right foot described as a fluid filled blister on 8/6/2024 from the foot resting on the foot board. On 8/16/2024, the pressure ulcer to the right foot was reclassified as a Stage 3 measuring 7 by 2 by 0.2. LPN C was Resident #151's wound/treatment nurse.</p> <p>7. Review of the medical record revealed Resident #171 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Colon, Abnormalities of Plasma Protein, Dysphagia, Atelectasis, Hypertension, Altered Mental Status, Anemia in Neoplastic Disease, and Open Wound, Left Lower Leg. Resident #171 was identified as being at risk for pressure ulcers on admission.</p> <p>Resident #171 developed a facility acquired pressure ulcer to the coccyx area on 8/19/2024 measuring 5 by 1.3 by 0.3 assessed as a Stage 3. LPN C was Resident #171's wound/treatment nurse.</p> <p>8. Review of the medical record revealed Resident #478 was admitted on [DATE], with diagnoses including Anoxic Brain Injury, Encephalopathy, Decubitus Ulcers, Pneumonia, Urinary Tract Infection, Peripheral Vascular Disease, Gastrostomy, Acute Respiratory Failure with Hypoxia, Epilepsy, Dementia, Alcohol Abuse, Pulmonary Edema, Quadriplegia.</p> <p>Resident #478 developed a facility acquired pressure ulcer assessed as a Stage 3 to the sacral area on 9/13/2023. Wound care treatments were ordered for every Monday, Wednesday and Friday. The wound care treatments to the sacral pressure ulcer were not performed every Monday, Wednesday and Friday from 10/1/2023 - 10/31/2023 as ordered.</p> <p>Resident #478 developed a facility acquired pressure ulcer assessed as a State 3 to the umbilicus area on 10/19/2023. Daily wound dressings/care was ordered. There was no documentation wound care was performed on 10/19/2023, 10/28/2023, 10/29/2023, 10/30/2023 and 10/31/2023.</p> <p>LPN C was Resident #478's wound/treatment nurse.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>9. Review of the medical record revealed Resident #479 was admitted on [DATE] with diagnoses including End Stage Renal Disease, Hemodialysis, Pulmonary Embolism, Heart Failure, Type 2 Diabetes Mellitus, Rheumatoid Arthritis, Morbid Obesity, Polyneuropathy, Unspecified Psychosis, Essential Hypertension, and Sarcoidosis.</p> <p>Review of LPN H's admission note for Resident #479 dated 8/11/2023 revealed the Resident was admitted with a State 3 pressure ulcer to the buttock and ischial area.</p> <p>Review of the NP's note for Resident #479 dated 8/14/2023 revealed the NP documented, .No reported impaired skin integrity concerns .</p> <p>Review of the Physicians note dated 8/14/2023 revealed to perform wound care to the buttock and ischial pressure ulcers once per day every Monday, Wednesday and Friday. Review of the treatment records for Resident #479 revealed the pressure ulcer wound care was not performed once per day every Monday, Wednesday and Friday as ordered form 8/14/2023 - 9/1/2023. LPN C assessed Resident #479/2 pressure ulcers inconsistently. LPN C was Resident #479's wound/treatment nurse.</p> <p>10. During an interview on 9/5/2024 at 11:00 AM, the Director of Nursing (DON) was asked if she was aware that some of the pressure ulcers had been identified once the pressure ulcers had reached a Stage 3. The DON stated, Yes . The DON was asked should the development of pressure ulcers be identified sooner. The DON confirmed if residents' skin was being checked and weekly nurse's assessments were being completed, she would expect the development of pressure ulcers to be identified before they reached a Stage 3. The DON was asked should pressure ulcer care/treatment be missed and not followed per physician orders.</p> <p>During an interview on 9/5/2024 at 4:55 PM, the Area Director of Clinical services confirmed this facility has had prior issues with pressure ulcers.</p> <p>Refer to F-686</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>48285</p> <p>Based on policy review, observation and interview, the facility failed to ensure medications were stored appropriately when Licensed Practical Nurse (LPN) I left one (1) of 9 medication storage areas (2nd floor Split Cart) unlocked, unattended, and out of line of site and when 3 of 7 nurses (LPN H, LPN L and Registered Nurse (RN)) F left medications unattended at the bedside.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Medication Storage dated 9/2023, revealed .All drugs .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 the medications or locked in the mediation storage area/cart .</p> <p>2. Observation on 8/21/2024 at 2:31 PM, revealed RN F in Resident #157's room. The RN placed a medication cup containing medications on the overbed table and went to the bathroom to wash their hands. The medication was left out of sight and unattended during this time.</p> <p>Observation on 8/22/2024 at 9:32 AM, revealed LPN H in Resident #45's room. The LPN placed the tray containing medications on the overbed table and went to bathroom to wash their hands. The medications were left out of sight and unattended during this time.</p> <p>During an interview on 8/22/2024 at 10:05 AM, LPN H stated, I should have taken the meds [medications] with me.</p> <p>Observation on 8/22/2024 at 11:10 AM, LPN I walked away from the 2nd floor Split Cart medication cart leaving the medication cart unlocked, unattended and out of the line of sight. Observation of the medication cart revealed a tube of Diclofenac Sodium Gel 1% was in the drawer with no label with Resident's name on it. LPN I stated it was Resident #379's medication.</p> <p>During an interview on 8/22/2024 at 11:14 AM, LPN I confirmed she should not have left the medication cart unlocked and out of the line of sight and medications should be labeled with the Resident's name.</p> <p>During an interview on 8/22/2024 the 2nd floor Assistant Director of Nursing stated, Cart [medication carts] should be locked and medications should be labeled with the resident name.</p> <p>Observation on 8/29/2024 at 10:18 AM, revealed LPN L entered Resident #173's room, placed the Resident's medications on the overbed table, walked away from the medications, went into the bathroom and left the Resident's medication out of her sight and unattended.</p> <p>During an interview on 8/29/2024 at 10:18, LPN L confirmed she should not have walked away and left Resident #173's medication out of sight and unattended.</p> <p>(continued on next page)</p>		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/5/2024 at 3:20 PM, the Director of Nursing confirmed nurses should not walk away from the medications, leave medications out of sight of staff, medication carts should be locked when unattended and out of sight and medications in the medication cart should be labeled with the Resident's name.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33379</p> <p>Based on policy review, observation, and interview, the facility failed to ensure food was stored properly when unlabeled, undated, and expired items were in 2 of 3 (200 hall and 400 hall) nourishment refrigerators observed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> The facility's policy titled, Use and Storage of Food Brought in by Family or Visitors revised [DATE], revealed .All food items .by the family or visitor brought in must be labeled .and dated .The facility may refrigerate labeled and dated .items in the nourishment refrigerator .If not consumed within 3 days, food will be thrown away by the facility staff . Observation in the 200 Hall Nutrition Room on [DATE] at 8:40 AM, revealed the following in the residents' nourishment refrigerator: <ul style="list-style-type: none"> A bottle of tea unlabeled and undated. A plastic container with a sandwich unlabeled and undated. A bag with a water bottle and container of watermelon, unlabeled and undated. <p>During an interview on [DATE] at 8:49 AM, the 2nd floor Assistant Director of Nursing (ADON) confirmed that staff and residents share the same nourishment refrigerator, and foods should be dated and labeled.</p> Observation in the 400 Hall Nutrition Room on [DATE] at 9:06 AM, revealed the following in the residents' nourishment refrigerator: <ul style="list-style-type: none"> A container with a Mexican meal unlabeled and undated. A jar of chunky salsa unlabeled and undated. A bottle of Jungle punch unlabeled and undated. A snicker ice-cream bar unlabeled and undated. <p>During an interview on [DATE] at 9:07 AM, Licensed Practical Nurse (LPN) E confirmed that items in the nourishment refrigerator should be dated and labeled.</p> <p>During an interview on [DATE] at 12:07 PM, the Administrator confirmed items in the nutritional refrigerators should be labeled and dated.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] at 12:23 PM, the ADON was asked were the nutritional refrigerators on the halls for both the residents and staff. The ADON stated, For residents only . The ADON confirmed items in the refrigerator should be labeled and dated .</p> <p>During an interview on [DATE] at 2:33 PM, the Dietary Manager (DM) confirmed the kitchen wasn't responsible for the nourishment refrigerators and stated, .on Fridays the housekeepers throw out everything that is not labeled and dated .and clean them out . The DM confirmed everything in the nourishment refrigerators should be labeled and dated.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>38439</p> <p>Based on policy review, job description review, medical record review, and interview, the Quality Assurance Performance Improvement (QAPI) committee failed to ensure a QAPI program that identified issues, implemented appropriate actions, and monitored the actions for residents with pressure ulcer/injuries and nail care for 7 of 10 (#27, #78, #123, #151, #171, #478, and #479) sampled residents reviewed for pressure ulcers, and 1 of 4 (Resident #105) sampled residents reviewed for activities of daily living.</p> <p>The findings include:</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. Review of the facility's policy titled Quality Assurance and Performance Improvement (QAPI), reviewed and revised 2/3/2024, revealed It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data- driven QAPI program that focuses on indicators of the outcomes of care and quality life and addresses all of the care and unique services that facility provides .The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee and a written QAPI Plan .The QAA Committee shall be interdisciplinary and shall .Consist at a minimum of .The Director of Nursing Services [DON], The Medical Director or his/her designee, at least three other members of the facility's staff .The Infection Preventionist .Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary .Develop and implement appropriate plans of action to correct identified quality deficiencies .Regularly review and analyze data, including collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements .The QAA committee must sign to verify approval of all plans of correction written .The QAPI plan will address the following elements .Tracking and measuring performances . Establishing goals and thresholds for performance improvements .Identifying and prioritizing quality deficiencies .Systematically analyzing underlying causes of systemic quality deficiencies .Developing and implementing corrective action or performances improvement activities .Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed .A prioritization of program activities that focus on resident safety, health outcomes .The facility must also consider the incidence, prevalence, and severity of problems or potential problems identified .The facility will maintain documentation and demonstrate evidence of its ongoing QAPI program .The QAPI program will be ongoing, comprehensive, and will address the full range of care and services provided by the facility .The governing body and /or executive leadership is responsible and accountable for the QAPI program .The facility maintains procedures for feedback, data collection systems, and monitoring, including adverse event monitoring .The facility draws data from multiple sources, including input from all staff, residents, families, and others as appropriate .Data is collected from all departments and is used to develop and monitor performances indicators .All identified problems will be addressed and prioritize, whether by frequency of data collection/monitoring or by the establishment of sub-committees .Considerations include .High-risk, high-volume, or problem-prone areas .Incidence, prevalence, and severity of problems in those areas .PIPs [Performance Improvement Projects] shall be designed to achieve and sustain performance improvement over time and to have an expected favorable outcome .Upon conclusion of the PIP, the sub-committee shall provide the QAA Committee with a report, which contains a summary and analysis of activities and recommendations for improvement .To ensure improvements are sustained, the effectiveness of performance improvement activities will be monitored in QAA Committee meetings in accordance with the QAPI plan, but no less than annually .</p> <p>2. Review of the signed Administrator's job description signed 10/1/2023, revealed .Lead and Direct the overall operations of the facility in accordance with customer needs, government regulations and Company policies, with focus on maintain excellent care for the residents .Duties and Responsibilities .Monitor each department activities, communicate policies, evaluate performance, provide feedback and assist observe, coach .Oversee regular rounds to monitor deliver of nursing care, operation of support departments .ensure resident needs are being addressed .Responsible for the QA (Quality Assurance) program .Maintain a working knowledge of and confirm compliance with all governmental regulations .</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the signed Director of Nursing (DON)'s job description signed 1/1/2024, revealed .To manage the overall operations of the Nursing Department in accordance with company policies, standards of nursing practices, and governmental regulations so as to maintain excellent care of all residents' needs . Management duties including .training and developing .In the absence of the Administrator and the Assistant Administrator .Monitor the Weekly Level of Care Report .and take appropriate action .Plan, develop, organize, implement, evaluate and direct the nursing services department as well as its programs .in accordance with current rules, regulations, guidelines that govern the long-term care facility .Assume administrative authority, responsibility and accountability for all functions, activities, and training of the nursing department .Organize, develop, and direct the administration and resident care of the nursing service department .Participate in Department Supervisor Meetings, Resident Care Plan Meetings, Quality Assessment and Assurance Committee Meetings, In Service Education .Participate in coordination of resident services .Meet monthly with nursing staff regarding Chart Audit and Physician's orders .Make daily rounds of the nursing department to verify that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards .Provide appropriate departmental in-service education programs in compliance with .State and Federal guidelines .Inform state of any reportable incidents within appropriate time frames .Complete investigative analysis .Make rounds with physicians as necessary .Schedule daily rounds to observe residents and to determine if nursing needs are being met . Regularly inspect the facility and nursing practices for compliance with federal, state, and local standards and regulations .Review and verify that documentation procedures for nursing are met according to .state and federal guidelines .Review nurses notes to confirm that they are informative and descriptive of the nursing care being provided, that they reflect the resident's response to the care .Review Quality Indicator reports .</p> <p>3. Review of a Performance Improvement Plan for the allegation of compliance for pressure ulcers put into place to address any citation and to prevent residents from suffering any adverse outcome and to prevent occurrence and reoccurrences from May 16, 2024 to June 2024, was as followed:</p> <ul style="list-style-type: none"> a. Identification of residents affected or likely to be affected b. All residents had an updated Braden Assessment completed between 5/16/2024 and 5/23/2024 c. Ensure initial skin assessments were completed d. Facility policies and procedures related to skin care, wound care, and pressure injury prevention were reviewed and revised e. Provided education to all licensed nurses on the completion of the Braden Score Assessment policy, and completed treatments on all new admissions f. Daily audit of the Treatment Administration Record to ensure accurate and complete documentation of skin related treatments as ordered g. Daily audits of skin related treatments including documentation, Braden Assessments, and orders. h. PIP initiated to report on above monitoring and will continue for 3 months. <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. The facility failed to ensure staff provided care and services consistent with professional standards of practice to appropriately identify PU/PIs, to prevent the development of PU/PIs, and to promote the healing of existing PU/PIs for at risk and vulnerable residents.</p> <p>Refer to F686.</p> <p>5. The facility failed to ensure, vulnerable residents who depended on staff for ADL care and services, was given toenail care which resulted in Actual Harm for Resident #105, when the resident's toenails adhere to the resident's skin that caused pain.</p> <p>Refer to F677.</p> <p>6. During an interview on 9/5/24 at 11:00 AM, with the Administrator and the Director of Nursing (DON), the Administrator confirmed that a Quality Assurance Performance Improvement meeting is held quarterly with the last meeting held on July 29,2024. The Administrator confirmed that all department heads along with Medical Director attends the meeting. The Administrator confirmed that the facility is currently working on falls, accident/incidents, the environment, and enhanced barrier precautions. The Administrator confirmed that a weekly wound meeting is held and she does not attend. The Administrator confirmed that she relies on the DON to keep her informed of pressure wounds, the number of pressure wounds and their progress. The Administrator confirmed she does not attend pressure wound meetings. The DON confirmed she was aware that pressure wounds were being found at a Stage 3. The DON confirmed that if resident's skin is being checked daily by CNAs (certified nursing assistants) and weekly by the wound nurses that no wound should be found at a Stage 3. The DON confirmed that the wound nurses should do their own assessments and should not use the assessment of the Wound Nurse Practitioner as their own assessments. The DON confirmed that she expects treatments for wounds to be completed as ordered and documented on the TAR (Treatment Administration Record). The Administrator confirmed she was unaware that pressure wounds were being found at a Stage 3 and that she should have been informed. The Administrator confirmed that the licensed nurses, including the wound nurses, are given yearly skills assessments with return demonstration. The DON confirmed that the 3 wound nurses were LPNs (licensed practical nurses). The DON confirmed that LPNs must be certified to stage pressure wounds. The DON confirmed that she was unaware that LPN H was not certified to stage pressure wounds and she should have been. The DON confirmed that she was the one who keeps the Medical Director informed of the wounds and their progress along with the wound nurses. The DON confirmed that the Medical Director is informed when he writes new orders for any change in treatments or supplements but no formal meeting given to the Medical Director other than in the QAPI meeting held quarterly. The DON confirmed she does not make rounds with the wound nurses unless they have a question about a wound.</p> <p>During an interview on 9/5/2024 at 4:20 PM, the Medical Director confirmed he was not aware that pressure wounds were being found at Stage 3 or higher in the facility and that the facility has protocols that should catch wounds before they get to a Stage 3 or higher. The Medical Director confirmed that the wound nurses should be able to stage pressure wounds and may need a higher level of degree.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Midtown Center for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 141 N McLean Blvd 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 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 9/5/2024 at 5:46 PM, the DON confirmed that the facility had a PIP in place for pressure ulcers that started 5/16/2024 and ended 6/24/2024. The DON confirmed the PIP was put into place because of the history of the facility to have large amounts of pressure wounds, the identification of Stage 3 pressure wounds, facility acquired pressure wounds and previous survey results related to wounds. The DON confirmed that the PIP consisted of full body assessments on all residents, turning and repositioning of residents, the Braden Scale assessment and completing treatments and documentation of the completion of treatments. The DON confirmed that identifying, assessment, staging, and documentation was not part of the PIP. The DON confirmed that she in serviced staff on the Pressure Wound policy dated 8/20/2022 and should have used the newly revised Pressure Ulcer policy dated 4/2024. The DON was asked was your PIP effective if there are wounds found at Stage 3, treatments that have not been documented as complete, and inconsistency of staging of wounds. The DON stated, Yes, I would day it was. The DON was asked with pressure ulcers being so important in the wellbeing of a resident how did 30 days of monitoring put you in compliance. The DON confirmed the PIP is ongoing and the monitoring for compliance has continued. The DON was asked if it is ongoing, how were wounds found at a Stage 3, treatments not documented on the TARs, and inconsistent staging found. The DON confirmed that only treatment documentations was part of the PIP.</p>		

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(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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48285</p> <p>Based on policy review, observation, and interview, the facility failed to ensure appropriate infection control prevention and practices during medication administration when 1of 7 nurses (Licensed Practical Nurse (LPN)) G observed failed to clean the rubber seal of the insulin pen before attaching the needle, when 4 of 7 nurses (LPN G, LPN I, LPN L and Registered Nurse (RN) F observed failed to implement appropriate hand hygiene, and when 1 of 7 nurses (LPN H) failed to clean reusable equipment between residents.</p> <p>The findings include:</p> <p>1. Review of the facilities policy titled, Insulin Pen dated 11/1/2023, revealed It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing .and serve as a teaching aid to prepare residents for self administration of insulin therapy upon discharge .Procedure .Gather supplies .Perform hand hygiene .Don gloves .Attach pen needle .Remove the pen cap from the insulin pen .Wipe the rubber seal with alcohol pad .Prime .Set the insulin dose .Injecting the insulin .Remove gloves and perform hand hygiene .</p> <p>Review of the facility's policy, Medication Administration dated 2/20/2024, revealed .Wash hands prior to administering medication per facility protocol .Wash hands using facility protocol and product .</p> <p>Review of the facility's policy titled, Hand Hygiene dated 3/22/2024, revealed .All staff will perform proper hand hygiene procedures to prevent the spread of infection .using proper technique .The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing the gloves .</p> <p>2. During an observation on 8/21/2024 at 3:40 PM, RN F went to medication room, came back to the medication cart and prepared medications, went to Resident room and administered medications. RN F failed to perform hand hygiene.</p> <p>Observation on 8/22/2024 at 9:32 AM, revealed LPN G took the blood pressure of Resident, went to medication cart to write the blood pressure results, took medications to the Resident's room and administered the medications. LPN G failed to perform hand hygiene.</p> <p>Observation on 8/22/2024 at 9:32 AM, revealed LPN H took a blood pressure cuff from the medication cart, took Resident #45's blood pressure, went back to the medication cart, prepared medications, administered medications, returned to medication cart, put supplies away and did not clean the blood pressure cuff before putting it away. LPN H failed to clean reusable equipment.</p> <p>Observation on 8/22/2024 at 11:17 AM, revealed LPN I prepared medications, entered Resident #159's room and donned gloves. LPN I failed to perform hand hygiene.</p> <p>Observation on 8/26/2024 at 2:21 PM, revealed LPN G gathered Resident #91's insulin pen and needle, placed the needle on the insulin pen and failed to clean the rubber seal of the insulin pen before attaching the needle.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 8/26/2024 at 2:57 PM, LPN G confirmed she failed to wipe the rubber seal of the insulin pen with an alcohol pad before attaching the needle.</p> <p>Observation in Resident #144's room on 8/27/2024 at 9:29 AM, revealed LPN G entered Resident room, administered the Resident's inhaler, removed her gloves, and failed to perform hand hygiene.</p> <p>Observation on 8/29/2024 at 10:18 AM, revealed LPN L failed to perform hand hygiene before dispensing Resident #173's medication.</p> <p>During an interview on 9/5/2024 at 3:20 PM, the DON confirmed the blood pressure cuff should be cleaned between use on Residents and hand hygiene should be performed during medication administration.</p>