

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/20/2025
NAME OF PROVIDER OR SUPPLIER  Majestic Gardens at Memphis Rehab & Snc		STREET ADDRESS, CITY, STATE, ZIP CODE  131 N Tucker Memphis, TN 38104	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on policy review, medical record review, observation and interview, the facility failed to provide care and services when 1 of 3 (Resident #18) discharged sample residents reviewed did not receive a personal refund within 30 days of discharge. The findings include: Review of the facility's policy titled Resident Funds Policy and Procedure, dated 2025, revealed .To ensure that.residents have access to, and are able to manage, their personal funds.Conveyance upon discharge, eviction, or death.Upon discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days, the resident's funds, and a final accounting of those funds, to the resident, his or her legal representative. Review of the medical record revealed Resident #18 was admitted on [DATE], with diagnoses including Psychotic Disorder with Delusions, Dementia, and Hypertension. Resident #18 was discharged to another facility on 12/13/2025. Review of the facility's Patient Fund Request Form dated 1/30/2025, revealed .Refund due to discharged on 12/13/2025 [Named Resident] .Closed account due to discharged . During a telephone interview on 8/19/2025 at 10:30 AM, Resident #18's daughter (responsible party) confirmed Resident #18's personal account was not received through the mail until 2/5/2025. During an interview on 8/19/2025 at 11:25 AM, the Business Office Manager and the Administrator confirmed the account was not refunded within 30 days.</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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