STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115561	A. Building B. Wing	03/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Health and Rehab	4608 Lawrenceville Highway Tucker, GA 30084

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)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38154 Based on record review, interviews, and review of the policy titled, F 655 Baseline Care Plans, the facility failed to complete a baseline care plan within 48 hours of admission for one of 22 sampled residents (R) (R#1). Findings include: Review of the policy titled 655 Baseline Care Plans revised 10/2022, revealed the policy is that a baseline care plan to meet the resident's needs shall be developed for each resident within forty-eight (48) hours of admission. Guideline number 4. The interdisciplinary team will review the attending physician's orders (e.g., dietary needs, medications, and routine treatments), and implement a baseline nursing care plan to meet the resident's immediate care needs. Number 6. Within 38 hours the summary of the baseline care plan should be presented to the resident and/or their representative in writing, in a manner and language they understand. The summary should include initial goals for the resident, a list of medications and dietary instructions, services and treatments to be administered by the facility. Number 7. Document evidence of the summary given to the resident or their representative in the medical record. R#1 was admitted to the facility on [DATE] with diagnoses to include but not limited to dehydration, pneumonia, altered mental status, Parkinson's Disease, and epilepsy. Review of the Discharge Minimum Data Set (MDS) assessment dated [DATE], documented adequate hearing and vision, unclear speech, rarely/never understands, and rarely/never understood. Staff were unable to complete the Brief Interview for Mental Status (BIMS) to numerically score the degree of cognitive impairment but documented long-term and short-term memory problem and severely impaired cognitive skills for daily decision-making. The assessment continued with a Mood score of 18, indicating severe depression, and noted no behaviors. R#1 was totally dependent on staff for activities of daily living (ADLs) except she required extensive assistance for eating. She received insulin, antibiotic, and diuretic medications. Review of the Baseline Care Plan for R#1 documented the admitted as 2/3/2023 and the effective date as 2/7/2023. Section Q. Signatures and Acknowledgment revealed there was no signature or date the base line care plan was discussed or provided to the resident and/or her representative. (continued on next page)

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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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/23/2023 at 4:00 p.m., Licensed Practical Nurse (LPN) QQ stated the Effective Date represented the completion date for the baseline care plan. She confirmed the Effective Date for R#1's baseline care plan was 2/7/2023. During further interview, she stated it should have been completed within 48 hours of admission. Interview on 3/23/2023 at 4:15 p.m., Interim Director of Nursing (IDON) reviewed R31's base line care plan and confirmed the effective date was 2/7/2023. She stated the base line care plan should have been completed within 48 hours of the residents admission. Interview on 3/25/2023 at 4:10 p.m., Administrator stated he expected the nursing staff to complete baseline care plans within 48 hours of admission per facility policy.

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146 Based on record review, interviews, and policy review, the Medical Director (MD) failed to assess and review admission medication orders for one resident (R) (R#1) being admitted to facility under his care. Specifically, R#1 was a direct admission from a community setting with orders from her primary care physician. The orders contained medications for another patient, and the orders were electronically signed by the MD, resulting in R#1 being admitted to the hospital with a diagnosis of dehydration, acute metabolic encephalopathy, and low blood sugar. The sample size was 22. On 3/20/2023 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Interim Director of Nursing, and Assistant Director of Nursing were informed of the Immediate Jeopardy (IJ) on 3/20/2023 at 3:09 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/3/2023. An Acceptable Removal Plan was received on 3/24/2023. The removal plan included in-service training for nursing staff on transcribing medication orders, medication administration, including competency checks for licensed staff, in-service training for medical staff on the policy of Physician Services and transcribing new residents' admission medication orders. Through observations, record review, and interviews the survey team verified all elements of the facility's IJ Removal Plan, and the immediacy of the deficient practice was removed on 3/22/2023. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). Findings include: Review of policy titled Physician Services F710 approved 5/2022, revealed each resident is under the supervision of a licensed physician. Policy Interpretation and Implementation number 1. The attending physician participates in the resident's assessment and care planning, monitoring changes in medical status, and provides consultation or treatment when called by the facility. Number 2. The physician is responsible for prescribing new therapy and ensures the resident receives quality care and medical treatment. Review of the Medical Director Agreement signed by MD CC on 10/30/2007 revealed Consulting Responsibilities number 1. Assume the administrative authority, responsibility, and accountability of implementing the medial services, policies, and procedures. Number 2. Coordinate medical care and implement methods to keep the quality of care under constant surveillance. Number 4. Ensure residents receive adequate services appropriate to their needs. Review of the clinical record revealed R#1 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, hypertension, epilepsy, pressure ulcer, and pneumonia. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident's Discharge Minimum Data Set (MDS) dated [DATE] revealed resident was rarely able to make herself be understood and rarely understood others. She was unable to complete the Brief Interview for Mental Status (BIMS). Review of admission paperwork from R#1 primary care physician (PCP) revealed an office note dated 10/22/2022, that documented active medications as clindamycin 300 milligrams (mg), ferrous gluconate 240 mg, hydrochlorothiazide-lisinopril 12.5 mg-10 mg, escitalopram 10 mg, Aricept 5 mg, Calcium 600 + D, and levetiracetam 500 mg. Included with R#1's active medication list was a list of medications belonging to another patient from the PCP's office, including atorvastatin 40 mg, cetirizine 10 mg, Plavix 75 mg, ergocalciferol 1.25 mg, Novolog 12 units three times a day, Lantus 24 units every night, Jardiance 10 mg, Cozaar 50 mg, metoprolol succinate ER 100 mg, Protonix 40 mg, torsemide 100 mg two times daily, and ferrous sulfate 325 mg. Review of Physician Note dated 2/6/2023 revealed that Nurse Practitioner (NP) BB saw R#1 at the facility on 2/6/2023. The note indicated medication reconciliation was done from a medication list from residents' primary physician from 2018/2019. She documented that Director of Nursing (DON) was to request current medication list from responsible party. The note revealed R#1's diagnoses include hypertension, osteoarthritis, and seizure disorder. The note was electronically signed by NP BB and dated 3/20/2023 at 12:26 p.m. Review of Physician Note dated 2/7/2023 labeled as Admission History and Physical dictated by Medical Doctor VV, revealed medication reconciliation was done from a med list from a 2018/2019 medical clinic visit note. The DON was asked to request a current medication list from R#1's responsible party. Continued review of the Admission History and Physical revealed past medical history included diagnoses listed but not limited to hypertension, osteoarthritis, and seizure disorders. The document indicated chronic medical problems, current documents, and current medications were reviewed. Continue medications and treatments as ordered. This note was electronically signed MD VV and dated 3/20/2023 at 12:26 p.m. Review of the orders transcribed in the EMR revealed the following medications were ordered and electronically signed by Medical Director CC. 1. losartan potassium 50 mg tablet, give 100 mg by mouth daily ordered on 2/3/2023. 2. Metoprolol Succinate ER 100 mg daily ordered on 2/3/2023. 3. Torsemide 20 mg give 100 mg twice a day ordered on 2/3/2023. 4. Hydrochlorothiazide (HCTZ) 12.5 mg ordered on 2/3/2023. 5. Jardiance 10 mg daily ordered on 2/3/2023. 6. Lantus 24 units subcutaneous at bedtime (hs) ordered on 2/3/2023. 7. Novolog 12 units subcutaneous before meals ordered on 2/3/2023. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 3/17/2023 at 10:41 a.m., NP BB revealed the admission process at the facility is that nursing calls the NP when a resident arrives for admission. If the resident arrives after hours, nursing calls the NP on call or telehealth. The nurse reviews diagnosis, age, and medications with the provider they contact. She revealed she spoke to the previous DON regarding R#1's medication list obtained from her primary care physician. She asked the DON to have the family bring the residents' current medications to the facility. She stated if any changes are made during the initial conversation with the admitting nurse, the nurse will document changes and what provider made the changes. She revealed when a nurse calls her with a new admission, she wants them to tell her the medications the resident is taking and the diagnosis that the resident has for that medication before she approves the medication to be given in the facility. She stated medications are entered into the EMR by the nurse, then the orders go to the pharmacy, and then to the Physician/Nurse Practitioner for verification and signature. During further interview, she stated she is not sure if she reviewed the list of medications that were transcribed into the EMR with the facility staff. Interview on 3/21/2023 at 11:01 a.m., MD CC revealed he was aware of the incident with R#1 receiving insulin and oral diabetic medications which resulted in a low blood sugar and receiving a diuretic that resulted in the resident blood pressure dropping and subsequently transferred to an acute care hospital for treatment. He stated that he did not have any conversations with R#1's community primary care physician prior to or after her admission to the facility. He stated when a resident is admitted to the facility then he and the physicians in his group become the residents primary care physician. He stated he was aware that she did receive insulin in error without an order, diagnosis of diabetes, or an order to monitor blood glucose levels. He stated he himself had not seen R#1 but one of his colleges had but stated he was not sure of the date. During further interview, he stated he did not believe there was a specific policy or admission process related to a resident admission from home. He stated his expectation is nursing receives orders/medication list to review then they call the physician and read the orders to the physician verbally over the phone for them to confirm and verify continuance of medications and/or treatments. The facility implemented the following actions to remove the IJ: 1. On 2/9/2023, upon receiving notification of a medication error that resulted in the hospitalization of R#l, the Administrator initiated an investigation during which the resident's attending physician was called to discuss the mixed medical records of another individual that was not caught by our nurse, and the referring physician was notified of the HIPAA breach by his office. The attending physician who is also our Medical Director, received education on 3/20/2023 by the Administrator regarding the policy on Physician Services to include that a physician's personal approval of an admission recommendation must be in written form. The written recommendation for admission to the facility must be provided by a physician and cannot be provided by an NP. This may be accomplished through a hospital transfer summary written by a physician, paperwork completed by the resident's physician in the community, or other written form by a physician. 2. Starting on 3/20/2023 and ending on 3/21/2023, the Administrator and/or the Assistant DON, RN, provided education to the Physicians and Nurse Practitioners about receiving & transcribing new residents' admission medication orders by a physician. Additionally, education included a review of the policy for Physician Services. 3 of 3 Physicians and 3 of 3 Nurse Practitioners received this education. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. On 2/10/2023, the Unit Manager(s) or ICP, LPN reviewed electronic medical records of current residents who were admitted to Meadowbrook H&R since 1/1/2023, to identify other residents with potentially incorrect admission medication orders, using the Admission Order Review Tool. Results of this audit identified that of the 8 residents admitted during this timeframe, no medication errors were identified. 4. Since 2/10/2023 there were 2 new admissions noted with medication errors in which the MD was notified of the medication error. There have been no noted adverse events related to these medication errors being identified. 5. On 2/10/2023, the facility conducted an AD Hoc QAPI meeting in order to determine the root cause of this medication error. It was determined that new admission orders were not being reviewed timely by the Interdisciplinary Care Plan Team (IDT). IDT members include the Administrator, Business Office, Clinical Reimbursement Coordinators, Wound Nurse, Director of Nursing, Assistant Director of Nursing, Unit Manager(s), Rehab Manager, SDC/IP, and Activities. The facility initiated a new system and process to review newly admitted residents' admission orders during the Interdisciplinary Team Meeting that occurs daily (M-F) using the Admission Order Review Tool. On weekends, the RN on duty will review new admission orders using the Admission Order Review Tool and the IDT will conduct a secondary review of the orders on Monday. The QAPI Committee members who attended this Ad Hoc QAPI meeting were the Administrator, Medical Records, Rehab Manager, Admissions, Business Office, Clinical Reimbursement Coordinators (MDS), Wound Nurse, Maintenance, Environmental, SDC/IP, Activities, all in person and the Medical Director via telephone. 6. Upon admission of a new resident, the admitting nurse on duty will contact the physician and review the list of medications with the physician. This may be completed verbally via telephone, fax/email, virtual conference, or an in-person meeting with the physician, including electronic signatures by physician. 7. Starting on 3/16/2023 and ending on 3/21/2023, education was provided to current licensed nurses regarding the facility's policies related to medication administration, new and readmission medication orders, diagnosis for each medication and only physicians may write admission orders, by the SDC/IP, Unit Manager and/or Assistant Director of Nursing or Director of Nursing. As of 3/21/2023 there are 26 licensed nurses employed at Meadowbrook Health and Rehab. This education was provided to 1 of 1 RN DON 1 of 1 RN ADON, 1 of 1 LPN Unit Manager, 3 of 3 other RNs, 1 of 1 Staffing Coordinator LPN, and 18 of 19 other LPNs. 25 of 26 total Licensed Nurses have received education and the facility's percentage of completion is 96.15% as of 3/21/2023. The remaining nurse will receive this education prior to working her next scheduled shift. The Physicians and Nurse Practitioners received separate education provided by the Administrator to 3 of 3 physicians and 3 of 3 NPs on 3/20/2023 & 3/21/2023. 8. On 3/20/2023 the existing policies for Admissions to Facility and Physician Services were reviewed by facility Administrator and Director of Nursing. Policies are found to be adequate to achieve substantial compliance. Job Descriptions for licensed nurses were also reviewed and found to be adequate. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	9. On 3/20/2023 the facility initiated an audit of the electronic medical records for current residents who were admitted since 1/1/2023, to ensure that the admission orders were written by a physician, using the Physician Admission Audit Tool. This audit was completed by the Interim Director of Nursing on 3/21/2023. Results of this audit identified that of the 25 residents admitted , 2 were admitted from a nursing home, 2 were admitted from home and 21 were admitted from a hospital. Errors found included: 1 of 2 residents admitted from home was identified with errors. R#l was 1 of the 2 admissions from home. 10. On 3/20/2023, an Ad Hoc QAPI meeting was conducted to review and discuss the Immediate Jeopardy Deficiencies. In attendance were: the Administrator, Interim DON, Human Resources, Social Services, Business Office, MDS x's 2, Admissions, Environmental, Maintenance, Unit Manager, Staffing Coordinator, in person. The Medical Director participated by telephone and the Governing Body Members X2 joined virtually. A root cause analysis was conducted and determined the facility must ensure that a Physician is writing admission orders. The facility's Performance Improvement Plan was reviewed and revised to include the additional interventions. 11. To ensure compliance is maintained, an ongoing audit of new admissions' orders will be conducted using the Admission Order Review Tool by the DON, ADON, and/or Unit Manager(s), to ensure that admission orders are correct, appropriate diagnosis is listed for medications present, and orders were written by a physician. The physician will be notified of any findings because of the audit. 12. Starting on 3/20/2023 and ending on 3/21/2023, the Administrator and/or the Assistant DON, RN, provided education to the Physicians and Nurse Practitioners about receiving new residents' admission medication orders by a physician. Additionally, education included a review of the policy for Physician Services. 3 of 3 Physicians and 3 of 3 Nurse Practitioners received this education. All corrective actions were completed on 3/21/2023. The facility alleges that the IJ is removed on 3/22/2023. Onsite Verification: The IJ was removed on 3/22/2023 after the survey team performed onsite verification that the Removal Plan had been implemented. Interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. 1. Review of handwritten notes by the administrator dated 2/9/2023 at 3:00 p.m. revealed the former DON reported to the Administrator the events that occurred during transcription of orders that lead to medication errors resulted in the hospitalization of R#1. His notes indicated a plan to educate nursing staff regarding 5 rights of medication administration, proper transcription of orders, verify documents belonging to the resident. An addendum was noted on 2/17/2023 that the nurse reviewed the original medication list with the family and the former DON found additional orders and instructed the nurse to verify with the Nurse Practitioner (NP) and put orders in the electronic medical record (EMR). (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of document titled Facility Incident #202301442 dated 2/9/2023 at 5:34 p.m. revealed the facility incident report was received and a follow up report was due on 2/16/2023. The report contained details of the documents received by the facility from R#1's community Primary Care Physician (PCP) contained documents belonging to another patient and how the nurse had mistakenly entered this patient's information into R#1's EMR. Education provided to the nursing staff dated 2/13/2023 regarding chart checks, 5 medication administration rights, chart checks and re-checks on all new admission and new orders, verify all with tele-health and NP. Review of facility incident report revealed R#1's admission medications were verified with NP BB by the former DON. Action that was taken R#1 was sent to the ER for low blood pressure. Action taken by the facility was the suspension of LPN AA for 3 scheduled shifts. Review of the facilities Census List revealed R#1 was readmitted to the facility on [DATE] at 4:11 p.m. Review of the facility's Incident Audit Report dated 2/13/2023 revealed a description of the incident involving transcription of orders incorrectly and why R#1 was sent to the hospital. Review of a letter dated 2/10/2023 to R#1's community PCP from the facility's Administrator informing him of the HIPAA breach because of the office sending documents related to another patient in the admission packet intended for R#1. This letter also informed the community PCP of the medication error that occurred which resulted in low blood pressure and transfer to the hospital for treatment. Review of Documentation dated 2/9/2023 of notification of the transcription error which led to medication errors that resulted in the hospitalization of R#1 and the letter sent to the community physician regarding the HIPAA breach. Review of In-Service Attendance Record dated 2/13/2023 revealed that 22 nurses received inservice titled Admission/Documentation. Supporting documents revealed topics discussed included but not limited to changes in condition, skin tears, falls, hospital returns, 5 medication rights, new admission paperwork, check all new orders with a second nurse and the following day a third chart check will occur during the IDT meeting. 2. Review of documentation of education provided for the physicians and mid-level provider revealed education related to new admission orders written by a physician. NP's can review orders for new admissions but cannot write new admission orders. Two of the three physicians received educational information via a telephone call on 3/20/2023 and 3/21/2023 from the Administrator. The third physician received education in-person on 3/20/2023 by the Administrator. Three of the three nurse practitioners received educational information from ADON on 3/21/2023. Documents reviewed with each provider included a policy titled Physician Services F710 last approved 5/2022 and the document titled Authority for Non-Physician Practitioners to Preform Visits, Sign Orders and Sign Medicare Part A Certifications/ Re-certification when Permitted by the State. 3. Reviewed audit tool that revealed no orders were transcribed incorrectly for 6 of the 8 residents. Reviewed these charts to verify this was correct. 4. Reviewed audit tool and resident EMR to verify the two with noted medication errors and no adverse effects were documented in relation to the errors. (continued on next page)

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F 0710 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Reviewed notes from AD Hoc QAPI meeting on 2/10/2023 and verified all persons listed above signed in. Reviewed the Admission Order Review Tool, policy titled QAPI Plan for Failure to Transcribe Orders and Complete Documentation last approved 1/2022, and the 5 Whys form. The plan was to review new admission and readmission orders utilizing the admission order review tool and re-educate staff. 6. Review of Inservice Attendance Record titled Medication order Transcription revealed 26 nurses received this education and policies reviewed during this in-service were Telephone Orders F711, F755 last approved 5/2022, Verbal Orders F711, F555 last approved 5/22/2022, and Writing Orders - General Principles last approved 5/2022. 7. Review of document titled Meadowbrook Staff Competency Audit Tool revealed competencies were completed for 20 of 21 LPN's on 3/20/2023 and 3/21/2023 and 5 RN's on 3/20/2023 and 3/21/2023. Competency check off completed for medication administration was completed on 3/20-3/21/23 for 20 of 21 LPN's and 5 of 5 RN's. 8. New employee checklist reviewed and includes training during orientation to include admission orders, medication administration, and transcription of orders provided by physician. 9. Reviewed audit tool and the EMR of each resident identified with the tool and verified each resident had admission orders that were signed by a physician. 10. Prior to the Ad Hoc meeting the Interim Director of Nursing (DON) and the Administrator received education related to ensuring proper oversight to ensure residents remain free for significant medication errors. This education was facilitated by the regional vice president and the [NAME] nurse consultant on 3/20/2023 at 4:00 p.m. Review of the Ad Hoc QAPI meeting held on 3/20/2023 at 6:30 p.m., revealed signature of each person listed above as in attendance of the meeting. Topic: reviewed IJ deficiencies and abatement plan. Review of the form titled 5 Whys revealed nursing staff failed to follow current policies and plan for re-education related to medications and orders. Policies reviewed were titled Admissions to the facility F620, F621, F710 last approved 5/2022, Physician Services F710 last approved 5/2022, and Staff Competency F726, F947, F941 last approved 5/2022. 11. Review of audit tool revealed the tool has been revised to include a place to acknowledge that the reviewer verified the admission orders are correct, appropriate diagnosis is listed for medications, and orders were written and signed by a physician. There is a place for notation of discrepancies and action taken to resolve the discrepancy found. 12. Review of documentation of education provided for the physicians and mid-level provider revealed education related to new admission orders written by a physician. NP's can review orders for new admissions but cannot write new admission orders. Two of the three physicians received educational information via a telephone call on 3/20/2023 and 3/21/2023 from the Administrator. The third physician received education in person on 3/20/23 by the Administrator. Three of the three nurse practitioners received educational information from ADON on 3/21/23. Documents reviewed with each provider included a policy titled Physician Services F710 last approved 5/2022 and the document titled Authority for Non-Physician Practitioners to Perform Visits, Sign Orders and Sign Medicare Part A Certifications/ Re-certification when Permitted by the State.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 47146 Based on record review, interviews, and policy review, the facility failed to ensure direct care nursing staff were adequately trained and evaluated to provide competent nursing care for three residents (R) (R#1, R#2, R #3) who were administered medications that were incorrectly transcribed into the electronic medical records (EMR). Specifically, R#1 was ordered and administered insulin, oral antidiabetic agents, and high dose diuretics that were ordered for another person; R#2 was ordered antihypertensive medication, but the incorrect medication type was transcribed and administered; and R#3 was ordered antidepressant medication, and the incorrect dosage was transcribed and administered. Sample size was 22. On 3/20/2023 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Interim Director of Nursing, and Assistant Director of Nursing were informed of the Immediate Jeopardy (IJ) on 3/20/2023 at 3:09 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/3/2023. An Acceptable Removal Plan was received on 3/24/2023. The removal plan included in-service training for nursing staff on transcribing medication orders, medication administration, including competency checks for licensed staff, in-service training for medical staff on the policy of Physician Services and transcribing new residents' admission medication orders. Through observations, record review, and interviews the survey team verified all elements of the facility's IJ Removal Plan, and the immediacy of the deficient practice was removed on 3/22/2023. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). Findings include: Review of the policy titled Medication Orders reviewed 5/2022, revealed the section titled Recording Orders number 1. When recording orders, specify the type, route, dosage, frequency, and strength of the medication ordered. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy titled Reconciliation of Medications on Admission reviewed 5/2022, General Guidelines number 4. Medication reconciliation helps to ensure that medications, routes, and dosages have been communicated to the attending physician and care team accurately. Steps in the procedure step 1. The nurse should obtain a medication history from the resident/family. This information should include all prescription medications, over-the-counter medications, herbal or dietary supplements, patches, creams, eye drops, inhalers, shots, and sample medications. Each medication should have a dose, route, frequency, and last dose taken recorded. Step 2. Ask resident/family for all physicians and pharmacies from which they have obtained medications. Step 3. Using an approved medication reconciliation form, list all medication from the medication history, the discharge summary, the previous medication administration record (MAR) (if applicable), physician records, pharmacy records and/or the admitting orders. Step 4. List the dose, route, and frequency. Step 5. Review the list to determine discrepancies. Step 6. If discrepancies are identified take action to resolve the discrepancy. Review of the policy titled Administering Medications F 760 reviewed 5/2022, revealed policy is medications shall be administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation number 2. Director of Nursing Services will supervise and direct all nursing personnel who administer medications. Number 3. Medications must be administered, and in accordance with the orders. Number 7. The individual administering medication must check the medication label three times to verify the right medication, right dose, right time, and right route of administration before giving the medication . Review of a document titled Primary Nurse RN/LPN Job Description reviewed 6/2021, revealed the job summary is assists nursing supervisor in responsibility for total resident care and maintains quality resident care following facility policies and procedures, federal and state regulations, and the nursing standards of practice. Performs any and all professional nursing duties as determined by qualifications and training. Essential functions include coordination with the health care team to assess, plan, implement, or evaluate resident care plans, monitor, record, and report symptom changes in resident conditions, and maintain accurate, detailed reports and records. Review of a document titled Director of Nursing Job Description reviewed 6/2021, revealed the job summary is to coordinate all departments relating to nursing. The DON is accountable for all functions, activities, training, and education of all nursing employees. Essential functions include develop and maintain nursing service objectives, standards of nursing practice, and policy and procedure manuals; evaluation of resident records to assure accuracy, care plans are current and complete, and residents are receiving optimal nursing care; supervise the direction of resident care; and coordinates and delegates nursing orientations and ongoing education for all nursing staff . Review of the Course Completion History for LPN AA, revealed there was no evidence that a competency evaluation had been completed for medication administration, use of the electronic medical record (EMR), documentation, or transcribing medication orders. Interview on 3/16/2023 at 5:00 p.m., LPN AA stated she has been employed at the facility since November of 2022. She stated she completed an orientation period but doesn't remember any specifics regarding what training she had during the orientation period. Interview on 3/20/2023 at 5:40 p.m., LPN QQ revealed she usually orientates new nurses to the unit. During further interview, she stated she assists with checking off the competency checklist during the new nurse orientation . (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 3/21/2023 at 3:00 p.m., Administrator revealed that LPN AA's computer-based training is incomplete because she was marked as in-active in the system. He stated that there was not a competency check list done for LPN AA. He stated his expectation was that all nursing staff complete a competency check off during their orientation period and then yearly during the facilities skills fair . Interview on 3/25/2023 at 2:40 p.m., ADON revealed the orientation check list is completed for all new staff during a 3-day preceptorship. She stated if the checklist is not completed within the three days, the orientation period may be extended or further education will be completed with the new employee. The facility implemented the following actions to remove the IJ: 1. LPN AA, as identified in the Immediate Jeopardy template, was suspended, pending investigation, on 2/9/2023, related to identification of the medication error for resident R#I. LPN AA was educated about new admissions paperwork, physician orders, and having a second nurse review the orders, by the Staff Development Coordinator on 2/13/2023. This employee normally works every other weekend. She returned to work on 2/18/2023. 2. On 3/20/2023, the facility initiated an audit of current licensed nurses using the Staff Competency Audit Tool to identify other licensed nurses with potential lack of evidence of completed competency evaluations related to medication administration and Physician Order Transcription. The competency evaluation included verbal assessment and observation of the nurses' ability to provide care and services related to medication administration and physician order transcription with acknowledgment of understanding of the facility's policies and procedures. The audit revealed that 3 of 26 current licensed nurses had documentation of a competency evaluation. On 3/20/2023 and 3/21/2023,competency evaluations regarding Medication Administration and Physician Order Transcription was provided to 25 of 26 current licensed nurses, including the 3 nurses previously identified. The remaining nurse will receive her competency evaluation prior to returning to work. 3. Starting on 3/16/2023 and ending on 3/21/2023, education was provided to current licensed nurses regarding the facility's policies related to medication administration, new and readmission medication orders, diagnosis for each medication and only physicians may write admission orders, by the SDC/IP, Unit Manager and/or Assistant Director of Nursing or Interim Director of Nursing. As of 3/21/2023 there are 26 licensed nurses employed at Meadowbrook Health and Rehab. This education was provided to 1 of 1 RN DON 1 of 1 RN ADON, 1 of 1 LPN Unit Manager, 3 of 3 other RNs, 1 of 1 Staffing Coordinator LPN, and 18 of 19 other LPNs. 25 of 26 total Licensed Nurses have received education and the facility's percentage of completion is 96.15% as of 3/21/2023. The remaining nurse will receive this education prior to working her next scheduled shift. 4. Upon hire, or upon use of contract licensed nurses, facility will ensure that education is provided about admission orders, medication administration, and transcription of ordersprovided by a physician, during the new hire orientation process which will be completed by the Staff Development Coordinator (SDC), Unit Manager (UM) or the Assistant Director of Nursing (ADON). The New Employee Orientation Checklist was revised on 3/20/2023 to include this additional education. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	All corrective actions were completed on 3/21/23. The facility alleges that the IJ is removed on 3/22/23. Onsite Verification: The IJ was removed on 3/22/2023 after the survey team performed onsite verification that the Removal Plan had been implemented. Interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. 1. Review of document titled Coaching/Progressive Disciplinary Action Form revealed LPN AA was suspended from employment on 2/9/23 related to identification of medication errors. On 2/13/23 LPN AA received training/education via telephone regarding protocol on new admission paperwork, readmission paperwork, physician orders, and second nurse review and check orders entered in EMR. On 2/18/23 employee returned to work with 1:1 education done on date of return. This document was signed by LPN AA and a supervisor on 2/9/23 and 2/10/23. Review of record of Inservice dated 2/13/23 titled Admission revealed 1:1 education completed regarding new admission, readmission paperwork, procedure, and verifying orders with physician, tele-health, or the attending. Review of admission order with a second nurse verifying the 6 patient rights and ensure all documents received have residents name identified. 2. Review of document titled Meadowbrook Staff Competency Audit Tool revealed competencies were completed for 20 of 21 LPN's on 3/20/2023 and 3/21/2023 and 5 RN's on 3/20/2023 and 3/21/2023. The competency check off completed for medication administration was completed on 3/20-3/21/2023 for 20 of 21 LPN's and 5 of 5 RN's. 3. Review of Inservice Attendance Record titled Medication Order Transcription revealed twenty-six nurses received education reviewing medication orders, telephone/verbal orders, admission process, admission medication verification, reconcile orders with physician, and perform audit of orders with second nurse at time orders are entered in the EMR. Policies reviewed during this in-service were Telephone Orders F711, F755 last approved 5/2022, Verbal Orders F711, F555 last approved 5/22/2022, and Writing Orders - General Principles last approved 5/2022. 4. Review of document titled New Employee Orientation Checklist updated 3/20/23, revealed line-item education new employees are provided during their orientation period which included but not limited to admission orders, medication administration, and transcription of orders provided by physician.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47146 Based on record review, staff interviews, and review of facility policies, the facility failed to ensure that one resident (R) (R#1) was free from significant medication errors, by failing to identify that admission medication orders for insulin, oral antidiabetic agents, and high dose diuretics were prescribed for another person. The orders were transcribed into R#1's electronic medical record (EMR), dispensed by the pharmacy and administered to the resident for three days, resulting in a change of condition and hospitalization for six days. In addition, the facility transcribed medication orders for R#2's metoprolol (antihypertensive medication) incorrectly and for R#3 trazadone (antidepressant medication) was transcribed incorrectly. The sample size was 22. On 3/20/2023 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Interim Director of Nursing, and Assistant Director of Nursing were informed of the Immediate Jeopardy (IJ) on 3/20/2023 at 3:09 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/3/2023. An Acceptable Removal Plan was received on 3/24/2023. The removal plan included in-service training for nursing staff on transcribing medication orders, medication administration, including competency checks for licensed staff, in-service training for medical staff on the policy of Physician Services and transcribing new residents' admission medication orders. Through observations, record review, and interviews the survey team verified all elements of the facility's IJ Removal Plan, and the immediacy of the deficient practice was removed on 3/22/2023. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). Findings include: Review of the policy titled Admission to facility F620, F621, F710 reviewed 5/2022, revealed policy interpretation and implementation number 2. Prior to admission of a resident the physician must provide the facility with information regarding the immediate care of the resident, including orders that state the type of diet, medications (including a medical condition or problem associated with each medication), and routine care orders. Review of policy titled Admission Orders F635 reviewed 5/2022, revealed policy interpretation and implementation number 1. Residents may be admitted to the facility on ly upon the written order of the resident's attending physician. Number 2. Physician orders for immediate care, obtained either written or verbal (telephone) should at minimum contain dietary, medications, if necessary, and routine care to maintain or improve the residents' functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the policy titled Reconciliation of Medications on Admission reviewed 5/2022, General Guidelines number 4. Medication reconciliation helps to ensure that medications, routes, and dosages have been communicated to the attending physician and care team accurately. Steps in the procedure step 2. Ask resident/family for all physicians and pharmacies from which they have obtained medications. Step 3. Using an approved medication reconciliation form, list all medications from the medication history, discharge summary, and the admitting orders. Step 5. Review the list to determine discrepancies. Step 6. If discrepancies are identified take action to resolve the discrepancy. Step 7. Document the findings and results of the action. Review of the policy titled Administering Medications F760 reviewed 5/2022, revealed policy is medications shall be administered in a safe and timely manner and as prescribed. Policy Interpretation and Implementation number 3. Medications must be administered, and in accordance with the orders. Number 18. Medications ordered for a particular resident may not be administered to another resident, unless permitted by State law and facility policy, and approved by the Director of Nursing Services. Review of policy titled QAPI Plan for Failure to Transcribe Orders and Complete Documentation revised 1/2022, Number 1. Immediate medical intervention for any issues, problems, or injury. Number 2. Notify physician (MD) and family and document. Number 3. Suspend the employee immediately that did not transcribe orders or chart issues that resulted in neglect. 1. Review of the clinical record revealed R#1 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, hypertension, epilepsy, and pressure ulcer, and pneumonia. The resident's Discharge Minimum Data Set (MDS) dated [DATE] revealed resident was rarely able to make herself be understood and rarely understood others. She was unable to complete the Brief Interview for Mental Status (BIMS). Section G revealed she was dependent on two staff persons for activities of daily living (ADL). Section I had no evidence R#1 had a diagnosis of diabetes, heart failure, or kidney failure. Section N revealed R#1 received insulin injections and diuretics three of the seven days of the look back period. Review of admission paperwork from R#1 primary care physician (PCP) revealed an office note dated 10/22/2022, that documented active medications as clindamycin 300 milligrams (mg), ferrous gluconate 240 mg, hydrochlorothiazide-lisinopril 12.5 mg-10 mg, escitalopram 10 mg, Aricept 5 mg, Calcium 600 + D, and levetiracetam 500 mg. Included with R#1's active medication list was a list of medications belonging to another patient from the PCP's office, including atorvastatin 40 mg, cetirizine 10 mg, Plavix 75 mg, ergocalciferol 1.25 mg, Novolog 12 units three times a day, Lantus 24 units every night, Jardiance 10 mg, Cozaar 50 mg, metoprolol succinate ER 100 mg, Protonix 40 mg, torsemide 100 mg two times daily, and ferrous sulfate 325 mg. Review of February 2023 Order Audit Report revealed orders for R#1 dated 2/3/2023 for Jardiance 10 mg one tablet by mouth one time a day for diabetes; Insulin Glargine Solution 100 unit/milliliter (ml), inject 24 unit subcutaneously one time a day for diabetes; Novolog Solution 100 unit/ml inject 12 units subcutaneously before meals for diabetes; Torsemide Tablet 20 mg, give 100 mg by mouth two times a day for edema. The orders were transcribed by Licensed Practical Nurse (LPN) AA, and Jardiance, Lantus and Novolog were discontinued on 2/6/2023 and the Torsemide was discontinued on 2/8/2023, after they were identified to be prescribed for another patient. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the February 2023 Medication Administration Record (MAR) revealed Jardiance 10 mg was administered to R#1 on 2/4/2023 at 9: 00 a.m., Insulin Glargine 24 units subcutaneously at 9:00 p.m. on 2/3/2023 and 2/5/2023; Torsemide 100 mg at 9:00 a.m. and 5:00 p.m. on 2/4/2023, 2/5/2023, 2/6/2023, 2/7/2023, and 2/8/2023 at 9:00 a.m.; and Novolog 12 units subcutaneously on 2/5/2023 at 4:00 p.m. Review of Progress Note dated 2/6/2023 at 7:40 a.m. revealed resident blood sugar (BS) is at 49. Went in resident [sic] room at about 6:00 a.m. for routine accu-check. BS presented to be at 49. Tried to give resident a glucerna [sic], resident teeth were clinched. Administered glucagon at 6:30 a.m. Rechecked BS at 6:45 a. m. BS went up to 57. Rechecked BS at 7:00 a.m. BS went back down to 49. Notified MD via telehealth. Have not spoke [sic] with doctor (MD) as of yet. Notified niece via phone. Niece stated she's coming to see resident soon. Resident VSS (vital signs stable). B/P (blood pressure) 126/80, HR (heart rate) 82, T (temperature) 96.6, RR (respiratory rate) 18, SPO2 (spot oxygen) 97. Will continue to monitor. Review of Progress Note dated 2/6/2023 at 8:53 a.m. revealed resident BS is 51 after drinking a can of Glucerna and lost [sic] breakfast. Nurse Practitioner (NP) BB gave an order to give another glucagon and hold all insulin until further evaluation. Review of Progress Note dated 2/6/2023 at 9:00 a.m. revealed Glucagon given on RUQ (right upper quadrant). Resident BS recheck in 15 minutes. Review of Progress Note dated 2/6/2023 at 2:50 p.m. revealed resident received new orders from NP BB to discontinue (d/c) all her insulin, put her on accu-check before meals and at bedtime (AC/HS). Review of Progress Note dated 2/8/2023 at 11:01 a.m. revealed resident BP is 73/48, NP BB notified. Resident given an order for NS 0.9% at 100 ml/hr for one liter. Resident is lethargic, not waking up. NP BB order [sic] to send her out for further evaluation. 911 called waiting for transfer. Review of Progress Note dated 2/8/2023 at 11:23 a.m. revealed resident received new orders from NP BB to d/c Torsemide, Metoprolol, Losartan, cetirizine, and start NS 0.9% at 100 ml/hr for one liter. Review of Progress Note dated 2/8/2023 at 11:26 a.m. revealed resident is weak, resident is not waking up, she is lethargic. Review of Progress Note dated 2/8/2023 at 12:04 p.m. revealed 911 came and took resident to [facility name] per NP BB's order. Resident BP is 80/44. Review of Physician Note dated 2/7/2023 labeled as Admission History and Physical dictated by MD VV, indicated he reconciled R#1's medications from a list from a 2018/2019 medical clinic visit note. The DON was asked to request a current medication list from R#1's responsible party. Continued review of the Admission History and Physical revealed past medical history included diagnoses listed but not limited to hypertension, osteoarthritis, and seizure disorders. The document indicated chronic medical problems, current documents, and current medications were reviewed. Continue medications and treatments as ordered. This note was electronically signed by MD VV and dated 3/20/2023 at 12:26 p.m. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the situation, background, assessment, and recommendation (SBAR) form dated 2/8/2023 at 12:07 p.m. revealed there was a change in R#1 condition. Her vital signs (VS) were BP 73/48, pulse (P) 77, respirations (R) 18, pulse oximetry was 98% on room air, and blood glucose (BG) was 117. History listed diagnoses but not limited to Parkinson's disease, hypertension, epilepsy, weakness, and pressure ulcer. There were no medication changes listed for the past week. Mental status was listed as unresponsiveness. Nursing observations, evaluation, and recommendations were -R#1 was lethargic, not waking up, R#1 did not eat, and BP was 73/44. PCP responded with normal saline 0.9% at 100 ml/hr times one liter. Review of hospital records dated 2/8/2023 revealed R#1 had two days of confusion, poor oral intake, low blood sugar, and was minimally responsive. Chest X-ray revealed possible pneumonia and labs suggestive of dehydration. Admitting diagnoses was dehydration with acute metabolic encephalopathy, hypoglycemia, pneumonia, and seizure disorder. Interview on 3/15/2023 at 3:56 p.m., family of R#1 stated she was admitted to the facility from home. She stated that the facility called her to inform her that the resident was transferred to the hospital on 2/8/2023 because her blood pressure was low, and she was not eating. Interview on 3/16/2023 at 5:00 p.m., LPN AA stated she was the admitting nurse on duty 2/3/2023 when R#1 was admitted . She reported the resident's niece brought a packet of documents with her from resident's PCP, which included an office visit note with a list of active medications. She stated she reviewed the list of medications with NP BB, who verified the medications via verbal telephone conversation. During a further interview, she revealed the previous Director of Nursing (DON) double-checked the documents and informed her that there was an additional medication list. The DON instructed LPN AA to notify NP BB to review and verify the additional medications and then she entered the medications into the EMR. She stated she was suspended from work because of the error she made in transcribing R#1 orders into the EMR. Phone Interview on 3/16/2023 at 5:30 p.m. with Pharmacists MM and NN, revealed the orders received from the facility for R#1 on 2/3/2023 were electronically signed by Medical Doctor (MD) CC. The Pharmacists verified that R#1 orders included Novolog 12 units subcutaneous three times a day before meals, Jardiance 10 ml orally daily, torsemide 100 mg twice a day and Lantus 24 units subcutaneous at bedtime. Review of an email correspondence from Pharmacist NN dated 3/15/2023 at 5:40 p.m., revealed the potential side effects R#1, who was [AGE] years old and weighed 115 pounds, could have encountered because of the significant medication errors that occurred due to the transcription errors made when LPN AA transcribed the wrong orders into the EMR: Jardiance works by blocking the reabsorption of glucose and sodium by the kidney, which results in increased glucose excretion, reduced blood glucose concentrations. Jardiance is used to improve glycemic control in adults with type 2 diabetes mellitus (DM) and to reduce the risk of cardiovascular (CV) death in adults with type 2 DM and established CV disease. Adverse Reactions: increased risk of hypoglycemia when combined with insulin. Symptomatic hypotension can occur after initiating Jardiance. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Novolog (Insulin aspart) is a rapid-acting insulin analog that is produced from a chemical modification of regular human insulin. Adverse Reactions: Hypoglycemia is the most common adverse reaction of insulin therapy. Severe hypoglycemia requiring emergency treatment is sometimes referred to as insulin shock. Torsemide is an oral loop diuretic used in the management of edema associated with heart failure, renal disease, or hepatic disease. Adverse Reactions: Torsemide can cause potentially symptomatic hypokalemia, hyponatremia, hypomagnesemia, hypocalcemia, and hypochloremia-associated metabolic alkalosis. Excessive diuresis may cause potentially symptomatic dehydration, hypovolemia, hypotension, and worsening renal function, including acute renal failure particularly in salt-depleted patients. Interview on 3/16/2023 at 12:10 p.m., Interim DON stated she was a travel nurse and has been working in the facility for about four weeks. She stated she was vaguely aware of the medication errors that occurred with R#1. She stated her expectation of the nursing staff was to check all paper orders and verify the resident's identity on each page. She further stated when transcribing orders, nurses should verify diagnosis with each medication and call the NP on call, physician, or telehealth to verify medication lists, prior to entering medications into the EMR. She further stated that a second nurse should verify that orders were entered correctly and if discrepancies are identified, they should be corrected immediately. 2. Review of the clinical record revealed R#2 was admitted to the facility on [DATE] with DM, hypertension (HTN), chronic kidney disease (CKD) stage 4, atrial fibrillation (A-fib). Review of Admission MDS dated [DATE] revealed she had a BIMs of 15 indicating no cognitive impairment. Section G revealed she required limited assistance with ADLs. Review of hospital discharge summary dated 2/28/2023 revealed current medications to continue included Vitamin D 50,000 units weekly and metoprolol succinate XL (extended release) 50 mg every day in the morning. Review of the Pharmacy Consultation Report dated 3/3/2023, revealed a discrepancy on the admission orders as follows: 1. Vitamin D 50,000 units by mouth weekly for 90 days is ordered according to the hospital After Visit Summary, but it is not being administered according to the electronic medical record. 2. Metoprolol succinate 24-hour extended release is ordered, but the immediate release product metoprolol tartrate is being administered once daily. Recommendation from the Pharmacist is to clarify these medication orders and to communicate with the prescriber and pharmacy as appropriate. There is a handwritten notation by the Director of Nursing indicating that the orders have been corrected on 3/6/2023. Review of March 2023 Physician Orders revealed metoprolol tartrate 50 mg every day was ordered 3/2/2023 and discontinued on 3/6/2023; metoprolol succinate 50 mg every day was ordered on 3/7/2023; Vitamin D 50, 000-unit one capsule every week on Friday was ordered 3/10/2023. (continued on next page)

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	115561	A. Building B. Wing	03/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Health and Rehab	4608 Lawrenceville Highway Tucker, GA 30084

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the March MAR revealed metoprolol tartrate (a short acting medication used to treat high blood pressure and usually administered two times daily) 50 mg daily was administered on 3/3/2023, 3/4/2023, 3/5/2023, and 3/6/2023 at 9:00 a.m. The order was discontinued after the 3/6/2023 dose and metoprolol succinate (a long-acting medication used to treat high blood pressure and usually administered once daily) XL 50 mg daily was ordered to start on 3/7/2023 at 9:00 a.m. Interview on 3/16/2023 at 1:10 p.m., R#2 revealed she was admitted to the facility for rehabilitation and was looking forward to getting to go home soon. She stated she was not aware that the blood pressure medication she was given was not the same as what she had been taking. During further interview, she stated no-one informed her that she was given the wrong blood pressure medicine. Interview on 3/16/2023 at 1:25 p.m., Interim DON verified that R#2 had a medication error that was a result of incorrect transcription of orders into the EMR. She stated the Physician order for R#2 was for metoprolol succinate 50 mg daily, but was transcribed into the EMR as metoprolol tartrate 50 mg daily. R#2 was administered the incorrect medication, metoprolol tartrate, for three days before the medication error was identified and corrected to metoprolol succinate. During further interview, she stated the consultant pharmacist identified the error on 3/3/2023, but she did not get the email message until 3/6/2023. 3. Review of the clinical record revealed R#3 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, HTN, ischemic heart disease, and bipolar disorder. Review of the Admission MDS dated [DATE] revealed she had a BIMs of 15 indicating no cognitive impairment. Section G revealed the resident required extensive assistance of two people for ADL's. Review of the hospital discharge summary dated 2/24/2023 revealed discharge medications listed include trazodone (a medication used to treat depression) 100 mg, two tablets by mouth every day at bedtime and next dose due was documented to be 2/24/2023 at 9:00 p.m. Review of February 2023 Physician Orders revealed trazodone 100 mg, one tablet nightly by mouth was ordered on 2/24/2023 and discontinued on 2/27/2023; trazodone 100 mg, two tablets by mouth nightly were ordered on 2/27/2023. Review of the February 2023 MAR revealed trazodone 100 mg was administered at 7:00 p.m. on 2/24/2023, 2/25/2023, and 2/26/2023. The order was discontinued on 2/27/2023 and trazadone 100 mg, two tablets were ordered to start on 2/27/2023 at 7:00 p.m. Interview on 3/16/2023 at 1:26 p.m., Interim DON verified and confirmed that R#3's order for trazodone 100 mg, two tablets orally at bedtime, but the medication was transcribed incorrectly as trazodone 100 mg, one tablet at bedtime. She stated her expectation is that the nursing staff are to notify the NP or Physician on call, or telehealth to verify all medication orders. During further interview, she stated the nurse should transcribe the orders into the EMR, and a second nurse should verify that orders were entered correctly and if discrepancies are identified, they should be corrected immediately. Interview on 3/16/2023 at 2:00 p.m., R#3 revealed she was admitted to the facility about two weeks ago. She stated she was not informed of any issues regarding her medications, or not being given the correct dosages. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility implemented the following actions to remove the IJ: 1. R#I, medical record reflects that on 2/6/2023 resident experienced a change of condition related to abnormal blood sugar readings, low blood sugar(s). On 2/6/2023 it is also noted that new orders were received from the Nurse Practitioner to discontinue existing medication orders for Insulin. After discontinuation, there were no further recorded low blood sugar readings on 2/6/2023. On 2/8/2023, R#I was noted with a change of condition related to low blood pressure and lethargy. The MD was notified, and R#I was subsequently transferred to the hospital on 2/8/2023. R#I returned to Meadowbrook Health and Rehab on 2/14/2023 from the hospital. R#I is receiving the correct medications per hospital discharge summary, noted that admission orders reviewed at time of return by NP. Since returning from the hospital, the resident has had no noted symptoms of hypotension or hypoglycemia. 2. On 2/9/2023, upon receiving notification of a medication error that resulted in the hospitalization of R#I, the Administrator initiated an investigation during which the resident's attending physician was called to discuss the mixed medical records of another individual that was not caught by our nurse, and the referring physician was notified of the HIPAA breach by his office. The attending physician who is also our Medical Director, received education on 3/20/2023 by the Administrator regarding the policy on Physician Services to include that physician's personal approval of an admission recommendation must be in written form. The written recommendation for admission to the facility must be provided by a physician and cannot be provided by an NPP. This may be accomplished through a hospital transfer summary written by a physician, paperwork completed by the resident's physician in the community, or other written form by a physician. 3. LPN AA, as identified in the Immediate Jeopardy template, was suspended, pending investigation, on 2/9/2023, related to identification of the medication error for resident R#I. LPN AA was educated about new admissions paperwork, physician orders, and having a second nurse review the orders, by the Staff Development Coordinator on 2/13/2023. This employee normally works every other weekend. She returned to work on 2/18/2023. 4. On 2/10/2023, the Unit Manager(s) or ICP, LPN reviewed electronic medical records of current residents who were admitted to Meadowbrook H&R since 1/1/2023, to identify other residents with potentially incorrect admission medication orders, using theAdmission Order Review Tool. Results of this audit identified that of the 8 residents admitted , no medication errors were identified. 5. On 2/16/2023, the 5-day follow-up investigation report from the 2/9/2023 initial report was submitted by the Administrator to the Georgia Department of Community Health. 6. On 3/20/2023, LPN AA completed a competency evaluation by the Unit Manager regarding medication administration and physician order transcription to include preventing significant medication errors and the facility's policies and procedures related to admission orders. LPN AA successfully completed her competency evaluation. On 3/20/2023 and 3/21/2023, competency evaluations regarding Medication Administration and Physician Order transcription were provided to 25 of 26 current licensed nurses, including LPN AA. The remaining nurse will receive her competency evaluation prior to returning to work. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7. On 3/20/2023, the facility initiated an audit of current licensed nurses using the Staff Competency Audit Tool to identify other licensed nurses with potential lack of evidence of completed competency evaluations related to medication administration and Physician Order Transcription. The competency evaluation included verbal assessment and observation of the nurses' ability to provide care and services related to medication administration and physician order transcription with acknowledgment of understanding of the facility's policies and procedures. The audit revealed that 3 of 26 current licensed nurses had documentation of a competency evaluation. On 3/20/2023 and 3/21/2023, competency evaluations regarding Medication Administration and Physician Order Transcription was provided to 25 of 26 current licensed nurses, including the three nurses previously identified. The remaining nurse will receive her competency evaluation prior to returning to work. 8. Upon hire, or upon use of contract licensed nurses, facility will ensure that education is provided about admission orders, medication administration, and transcription of orders provided by a physician, during the new hire orientation process which will be completed by the Staff Development Coordinator (SDC), Unit Manager (UM) or the Assistant Director of Nursing (ADON). The New Employee Orientation Checklist was revised on 3/20/2023 to include this additional education. 9. Starting on 3/16/2023 and ending on 3/21/2023, education was provided to current licensed nurses regarding the facility's policies related to medication administration, new and readmission medication orders, diagnosis for each medication and only physicians may write admission orders, by the SDC/IP, Unit Manager and/or Assistant Director of Nursing or Interim Director of Nursing. As of 3/21/2023 there are 26 licensed nurses employed at Meadowbrook Health and Rehab. This education was provided to 1 of 1 RN DON 1 of 1 RN ADON, 1 of 1 LPN Unit Manager, 3 of 3 other RNs, 1 of 1 Staffing Coordinator LPN, and 18 of 19 other LPNs. 25 of 26 total Licensed Nurses have received education and the facility's percentage of completion is 96.15% as of 3/21/2023. The remaining nurse will receive this education prior to working her next scheduled shift. 10. Review of completed audits and new audit tools was incorporated by the Administrator into the facility's Ad Hoc QAPI meeting that was held on 3/20/2023 and into subsequent QAPI meetings to be held at least quarterly. The facility implemented the following actions to remove the IJ: 1. Confirmed by Progress Notes dated 2/6/2023 through 2/8/2023. 2. The Administrator filed a Facility Incident Report on 2/16/2023 related to the medication error for R#1. Confirmed correspondence to the referring physician regarding the HIPAA breach and medication error. 3. Confirmed suspension and re-education of LPN AA related to admission process, verification of physician orders with another nurse and the attending physician or telehealth physician, confirmation of name on all paperwork, and the 5 Rights of Medication +1 for Communication. 4. Review of the Admission Order Review Tools for 6 residents revealed no errors in admission order transcription. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. Results of the facility investigation of the medication error were sent to Department of Community Health (DCH) on 2/9/2023 at 5:43 p.m. 6. Clinical competencies completed for 26 nurses, including the CRC, DON, & ADON related to medication administration. 7. Staff competency audit tool and competencies completed on 3/21/2023. 8. New Employee Orientation Checklist was updated on 3/20/2023. 9. 3/20/2023 - 3/21/2023: education provided for nurses related to medication order transcription, telephone orders, verbal orders, new admission paperwork, & QAPI oversight. 10. Policy: QAPI for Failure to Transcribe Orders and Complete Documentation, reviewed 1/2023-no concerns.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38154 Based on record review, staff interviews, and review of the job description for the Administrator and the Director of Nursing, the facility administration failed to provide oversight and monitoring of the nursing staff to ensure medication orders were transcribed correctly to prevent the incidences of medication errors for three of 22 sampled residents (R) (R#1, R#2, R#3). On 3/20/2023 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Interim Director of Nursing, and Assistant Director of Nursing were informed of the Immediate Jeopardy (IJ) on 3/20/2023 at 3:09 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 2/3/2023. An Acceptable Removal Plan was received on 3/24/2023. The removal plan included in-service training for nursing staff on transcribing medication orders, medication administration, including competency checks for licensed staff, in-service training for medical staff on the policy of Physician Services and transcribing new residents' admission medication orders. Through observations, record review, and interviews the survey team verified all elements of the facility's IJ Removal Plan, and the immediacy of the deficient practice was removed on 3/22/2023. The facility remained out of compliance while the facility continues management level staff oversight as well as continues to develop and implement a Plan of Correction (POC). Findings include: Review of the Administrator Job Description reviewed 3/20/2023, revealed the job summary is to supervise, plan, develop, monitor, and maintain appropriate standards of care throughout all departments in the nursing home. Manages staff at the facility. Essential Functions include supervise and provide guidance and support to department heads. Review of the Director of Nursing Job Description reviewed 6/2021, revealed the job summary is to coordinate all departments relating to nursing. The DON is accountable for all functions, activities, training, and education of all nursing employees. Essential functions include develop and maintain nursing service objectives, standards of nursing practice, and policy and procedure manuals; evaluation of resident records to assure accuracy, care plans are current and complete, and residents are receiving optimal nursing care; supervise the direction of resident care; and coordinates and delegates nursing orientations and ongoing education for all nursing staff. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. R#1 was admitted to the facility on [DATE] with diagnoses of Parkinson's Disease, hypertension, epilepsy, pressure ulcer, and pneumonia. She was a direct admission from the community. She brought with her a packet of information from her primary care physician (PCP) with medication orders. Included in the packet was a list of medications that had another person's name on them. Licensed Practical Nurse (LPN) AA transcribed both medication lists into residents' electronic medical record, without identifying that the additional list of meds had another name on it. Resident was administered the wrong medications for five days including Jardiance, Lantus Insulin, Novolog Insulin, and Torsemide and had a decline in condition with lethargy and not waking up with a blood pressure of 73/48 and was hospitalized for six days. The resident did not have a diagnosis of diabetes, heart failure, or kidney disease. LPN AA was suspended on 2/9/2023 for three days. Upon her return on 2/18/2023, she was educated to the Five Rights of Medication Administration, transcribing admission orders, and confirming admission orders with a physician. The former Director of Nursing (DON) resigned her position on 2/13/2023 . 2. R#2 was admitted to the facility on [DATE] with DM, hypertension (HTN), stage 4 chronic kidney disease (CKD), and atrial fibrillation (A-fib). She was admitted from an acute care hospital. The hospital discharge summary indicated resident was to continue Vitamin D 50,000 units weekly and metoprolol succinate XL (extended release) 50 milligrams (mg) every day in the morning. Registered Nurse (RN) JJ transcribed the metoprolol succinate XL (a long-acting medication used to treat high blood pressure and usually administered once daily) as metoprolol tartrate (a short acting medication used to treat high blood pressure and usually administered two times daily). The Vitamin D 50,000 units was missed being transcribed until 3/10/2023, 9 days after admission. Multiple attempts to contact RN JJ for an interview were unsuccessful. 3. R#3 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes, HTN, ischemic heart disease, and bipolar disorder. She was admitted from an acute care hospital. Review of the hospital discharge summary indicated discharge medications include trazodone (a medication to treat depression) 100 mg, two tablets by mouth every day at bedtime. Next dose due was documented to be 2/24/2023 at 9:00 p.m. RN HH transcribed the trazadone dosage incorrectly as 100 mg, instead of the prescribed 200 mg. Interview on 3/16/2023 at 8:20 a.m. with RN HH, when asked how she knew orders for a new resident were entered correctly, she replied she trusted the system and believes orders are entered correctly. Interview on 3/23/2023 at 4:15 p.m., Interim DON stated the Administrator should be kept informed of pertinent clinical matters when they are identified and should not be withheld . Interview on 3/25/2023 at 4:10 p.m., Administrator stated he should have been informed of the incident when nursing determined there was significant medication error. He stated usually does not participate in the clinical portion of the morning meetings but relied on the nursing management to keep him informed of important clinical concerns. Cross Refer F760 The facility implemented the following actions to remove the IJ: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The Director of Nursing at the time that the R#l medication error occurred, is no longer employed at Meadowbrook H&R. She resigned her position with her last day of employment being 2/13/2023. The Interim Director of Nursing was appointed on 2/13/2023. 2. On 3/17/2023, an initial audit was conducted by the Interim DON for current residents with medication orders for insulin and accu-checks to ensure that an appropriate diagnosis for medication was present in the residents' electronic medical records and in the physician order for the medication. No discrepancies were found. 3. On 3/20/2023, the Regional Nurse Consultant and Regional VP of Operations, via Zoom conference, provided education to the Administrator and the Interim Director of Nursing regarding providing oversight to ensure that admission medication orders are accurate & services provided by a physician, ensuring staff competencies on these topics are completed, and facility's job descriptions were also reviewed for the positions of Administrator and Director of Nursing and found adequate. The Administrator will provide weekly oversight and monitoring of the results of medication audits, and the audit tools to ensure that compliance is maintained and will incorporate any findings into the facility's QAPI meetings to develop additional Performance Improvement Plans or Root Cause Analysis that should be indicated. 4. On 3/21/2023, the IDT team was re-educated by the Interim DON and/or Administrator that newly admitted residents' orders must be reviewed in the daily meeting that occurs M-F, to ensure accuracy. Participants in the IDT are the DON, MDS, Dietary, Nursing Unit Manager, Social Services, and Activities. 5. Review of completed audits and new audit tools was incorporated by the Administrator into the facility's Ad Hoc QAPI meeting that was held on 3/20/2023 and into subsequent QAPI meetings that are held at least quarterly. All corrective actions were completed on 3/21/2023. The facility alleges that the IJ is removed on 3/22/2023. Onsite Verification: The IJ was removed on 3/22/2023 after the survey team performed onsite verification that the Removal Plan had been implemented. Interviews were conducted with staff to ensure they demonstrated knowledge of the facility's policies and procedures. 1. Confirmed by a Separation Notice for the former DON, dated 2/13/2023. In addition, correspondence with DCH, dated 2/16/2023, notified DCH of the appointment of the Interim DON on 2/13/2023. 2. Confirmed audit was conducted, dated 3/16/2023, and signed by the Interim DON. 3. The Administrator's Job Description was reviewed with the RVP & RNC on 3/20/2023. 4. Confirmed by in-service sign-in sheet including the CRC. 5. Audit tools include: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Admission Order Review Tool b. Competency: Medication Administration c. New Employee Orientation Checklist d. Physician Admission Audit Tool e. Staff Competency Audit Tool