STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055401	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Post Acute	461 E. Johnston Avenue Hemet, CA 92543

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 48000 Based on interview, medical record review, and facility Policy and Procedure (P&P) review, the facility failed to ensure: 1. A system was developed and implemented to accurately track the movement of controlled medications (medications with high potential for abuse or addiction) to prevent and identify loss or potential diversion (illegal distribution or use for purposes not intended by the prescriber) of controlled medications when the facility was unable to account for the missing controlled medications for ten residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10). This failure had resulted in controlled medication abuse or diversion. 2. Accurate accountability of controlled medications. During a random controlled medication audit for four of six sampled residents (Residents 9, 11, 12, and 13), the controlled medications were signed out of the Count Sheet (a controlled medication record, an inventory sheet that keeps record of the usage of controlled medications) but not documented on the Medication Administration Records (MAR) to indicate they were administered to the residents. This failure resulted in inaccurate accountability of controlled medications, which had the potential for misuse or diversion. Findings: On August 26, 2024, at 8:40 a.m., an unannounced visit was made to investigate a facility report of an unusual occurrence regarding missing controlled medications. 1. During an interview on August 26, 2024, at 9 a.m.,with the Director of Nursing (DON), the DON stated, on the morning of August 16, 2024, the DON received a phone call from Licensed Vocational Nurse (LVN) 1 about missing controlled medication count sheets and controlled medication cards for two residents (Residents 4 and 9). (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON, after being informed by LVN 1, the same day, started the investigation. The DON stated the investigation included inspection of all medication carts, nursing stations, medication disposal areas, medication disposal bins, trash cans, paper document shred bins, rechecked controlled medication count, reviewed recent MAR, and interviewed nursing staff. The DON stated the investigation identified a total 10 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, and 10) that were missing controlled medication count sheets and controlled medication cards. The DON stated all residents who were missing controlled medications received refills from the pharmacy and no residents missed doses of medications. The DON stated, based on the information gathered through the investigation, the facility suspected the new hire per diem nurse, LVN 2, to have diverted the missing controlled medications. The DON further added, a police report was filed the same day and LVN 2 was no longer employed at the facility. During the same interview, the DON described the facility ' s process of receiving pharmacy deliveries of controlled medications as follows: - When a pharmacy delivery arrived, nursing staff placed the pharmacy Packing Slip in a bin for Medical Records; - Nursing staff filed the count sheet in the narcotic (controlled substance) logbook; and - Then locked the controlled medication card in the designated controlled medication drawer in the medication cart. During the same interview, the DON further added, if the controlled medication count sheet and medication card were missing, the loss would not have been identified immediately. The DON acknowledged there was no process implemented to monitor the receipt of controlled medications. During a follow-up interview on August 26, 2024, at 2:40 p.m., with the DON, the DON stated, she had not monitored the controlled medication inventory, usage, or medication administration records. During a follow-up interview on August 26, 2024, at 4:30 p.m., with the DON, the DON stated, there was no controlled medication reconciliation process implemented to identify loss or potential diversion of controlled medications. The DON acknowledged there should have been a process. During a review of the facility ' s P&P titled, Controlled Substances, dated November 2022, the P&P indicated, Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up .The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records; c. Declining inventory records; and d. Destruction, waste and return to pharmacy records .The director of nursing services documents irreconcilable discrepancies in a report to the administrator . 2. a. Resident 11 had a physician's order, dated July 30, 2024, for Norco (hydrocodone-acetaminophen, a potent controlled medication for pain) 5/325 milligram (mg, unit of measurement) tablet, 1 tablet by mouth every 12 hours as needed for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on August 26, 2024, at 12:13 p.m., with LVN 3, LVN 3 stated, when administering pain medication to a resident, nurses needed to sign out from the count sheet and document on the MAR immediately. LVN 3 stated the count sheet should match the MAR. During a concurrent interview and record review on August 26, 2024, at 12:30 p.m. with LVN 3, a review of Resident 11's Count Sheet for Norco 5/325 mg and MAR dated August 2024 indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - August 18, 2024, at 12 p.m.; and - August 23, 2024, at 1 p.m. During this interview and record review, LVN 3 acknowledged two Norco 5/325 mg tablets for Resident 11 were unaccounted. LVN 3 stated, nurse should have documented on the MAR. During a concurrent interview and record review on August 26, 2024, at 4:50 p.m., with the DON, Resident 11's Count Sheet for Norco 5/325 mg and MAR dated August 2024 were reviewed. The DON confirmed the discrepancies on the dates and times as listed above and acknowledged two Norco 5/325 mg tablets were unaccounted for resident 11. The DON stated, the doses should have been documented on the MAR. b. Resident 12 had a physician's order, dated October 26, 2023, for Norco 5/325 mg tablet, 1 tablet by mouth every 6 hours as needed for moderate pain (5 -7). During a concurrent interview and record review on August 26, 2024, at 12:45 p.m., with LVN 3, a review of Resident 12's Count Sheet for Norco 5/325 mg and MAR dated August 2024 indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - August 12, 2024, at 2:30 a.m.; - August 13, 2024, at 9:04 p.m.; - August 14, 2024, at 2:30 a.m.; - August 14, 2024, at 7:30 a.m.; - August 14, 2024, at 3 p.m.; - August 14, 2024, at 11:30 p.m.; - August 15, 2024, at 6 a.m. (or 4 p.m.); and - August 25, 2024, at 5:30 p.m. During this interview and record review, the LVN 3 acknowledged eight Norco 5/325 mg tablets for Resident 12 were unaccounted and should have been documented on the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on August 26, 2024, at 4:56 p.m., with the DON, Resident 12's Count Sheet for Norco 5/325 mg and MAR dated August 2024 were reviewed. The DON confirmed the discrepancies on the dates and times as listed above and acknowledged eight Norco 5/325 mg tablets were unaccounted for Resident 12. The DON stated, the doses should have been documented on the MAR. c. Resident 9 had a physician's order, dated August 13, 2024, for Ativan (a controlled medication used to treat anxiety) 1 mg tablet, 1 tablet every 6 hours as needed for anxiety. During a concurrent interview and record review on August 26, 2024, at 3:43 p.m., with the DON, a review of Resident 9's Count Sheet for Ativan 1 mg and MAR dated August 2024 indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - August 15, 2024 (time illegible, looked like 6:30am); and - August 16, 2024, at 9 a.m. During this interview and record review, the DON acknowledged two Ativan 1 mg tablets for Resident 9 were unaccounted and should have been documented on the MAR. d. Resident 13 had the following physician's orders: - August 8, 2024, for Ativan 0.5 mg tablet, 1 tablet every 6 hours as needed for anxiety; and - August 23, 2024, for Ativan 0.5 mg tablet, 1 tablet every 6 hours as needed for anxiety. A record review of Resident 13's Count Sheet for Ativan 0.5 mg and MAR dated August 2024 indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - August 15, 2024, at 12 p.m.; - August 17, 2024, at 9 a.m.; - August 19, 2024, at 9 a.m.; and - August 25, 2024, at 7:42 p.m. During a concurrent interview and record review on August 27, 2024, at 4:30 p.m., with the DON, Resident 13's Count Sheet for Ativan 0.5 mg and MAR dated August 2024 were reviewed. The DON confirmed the discrepancies on the dates and times as listed above and acknowledged four Ativan 0.5 mg tablets were unaccounted for Resident 13. The DON stated, the nurse should have documented on the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled, Medication Administration, dated April 2019, the P&P indicated, The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones .the individual administering the medication records in the resident's medical record .the date and time the medication was administered .the dosage .the route of administration .the signature and title of the person administering the drug. Further review of the facility ' s P&P titled, Controlled Substances, dated November 2022, indicated, .an individual resident-controlled substance record is made for each resident who will be receiving a controlled substance .This record contains .name of the resident .name and strength of the medication .quantity received .number on hand .time of administration .method of administration .signature of nurse administering medication.