STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075367	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook of Granby	350 Salmon Brook Street Granby, CT 06035

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on review of the clinical record, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for quality of care, the facility failed to notify the physician of critical lab values timely. The findings include: Resident #1's diagnoses included methicillin resistant staphylococcus aureus infection, urinary tract infection, dysphagia, and depression. The RCP dated 1/21/2024 identified Resident #1 was receiving intravenous (IV) therapy (Vancomycin) for recurrent UTI's (urinary tract infection). Interventions directed to monitor intake and output every shift, and to administer IV Vancomycin as ordered. A physician order dated 1/21/2024 directed to obtain lab work for CBC (complete blood count) with differential, CMP (comprehensive metabolic panel), ESR (erythrocyte sedimentation rate), CRP (c-reactive protein), and a Vancomycin trough weekly on Mondays. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had severely impaired cognition and received IV antibiotics. Nursing note dated 2/5/2024 (a Monday) identified Resident #1 had a vancomycin trough drawn at 9:50 AM. Review of Resident #1's lab results dated 2/5/2024 (a Monday) at 4:15 PM identified the lab results were called into the facility and reported to [NAME] by Lab Technician (LT) #1. Results were read back to the caller and results have been faxed to the requester. Resident #1 had the following critical labs results: 1. BUN was 77 (normal range is 10-24). 2. Creatinine was 4.1 (normal range is 0.7-1.5). 3. Vancomycin Trough was greater than 50 (normal 10 to 20). Review of the Fax Results/Received History for the facility identified Resident #1's lab results were faxed to the facility on [DATE]. Although requested, the facility was unable to provide the cover page included for Resident #1's lab results sent on 2/5/2024. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the SBAR Communication Form and Progress Note dated 2/6/2024 at 1:00 PM by the ADON identified Resident #1 had elevated Vancomycin trough and declining kidney function labs. Reported to MD #1 with new recommendation to transfer Resident #1 to the hospital. Family and NP #1 were in the facility and aware. Clinical record review failed to identify the facility called for lab results, or acted on lab results prior to 2/6/2024 at 1 PM (28 hours after the labs were drawn). Review of Person #1's provided documentation identified on 2/6/2024 at 1:04 PM, Person #1 notified the Infectious Disease (ID) office nurse/RN #2 regarding Resident #1's critical lab values from 2/5/2024, and the ID office was not aware of the critical lab values. The documentation indicated the ID office nurse/RN #2 then called the facility regarding the lab results. Review of the clinical record failed to identify the ID physician was notified of the critical lab values prior to notification by Person #1 at 1:04 PM (28 hours after the lab work was drawn). Interview with the ADON on 6/5/2024 at 12:45 PM identified the RN supervisor during the shift is responsible for handling any incoming lab results that are sent to the facility. The ADON stated lab results will also be faxed to the facility, and the results will be printed in the secretary's office. The ADON stated she was unaware if any staff reported the critical lab results to MD #1's office, and was unable to provide documentation that MD #1 was notified of the lab results prior to 1 PM (28 hours after the lab work was drawn). Further, the ADON identified the facility does not have an employee named [NAME] and was unable to verify who the results were reported to. Interview with RN #2 (Outpatient Infectious Disease RN) on 6/5/2024 at 1:05 PM identified on 2/6/2024, the office received a phone call from Person #1 indicating Resident #1 had critical lab values and wanted to ensure if MD #1 was aware. RN #2 identified at that time; the office had not received any results from the facility and had not received any messages requesting a call back or messages during off hours with results. RN #2 called the facility and spoke to the ADON, who verified the critical lab results for Resident #1. RN #2 questioned the ADON as to why the office was not notified sooner, and the ADON responded they were working on the issue. RN #2 reported the results to MD #1, and MD #1 called the facility and directed to transfer Resident #1 to the hospital for evaluation. Interview and review of physician documentation with MD #1 on 6/5/2024 at 1:15 PM identified reviewing his own notes, he was notified of Resident #1's critical lab values by his office team on 2/6/2024 and stated the facility did not update him or his office of the critical lab values. MD #1 stated when he was notified on 2/6/2024 he called the facility to direct Resident #1 to be transferred to the hospital. although interview identified MD #1 would have wanted to be notified of the critical lab results on 2/5/2024, and he was aware it was alleged Resident #1 received an extra dose of Vancomycin, the extra dose would not have harmed or impacted Resident #1's overall scenario. MD #1 stated the hospital nephrologist indicated Resident #1 was admitted with acute kidney failure related to acute tubular necrosis secondary to Vancomycin toxicity and worsening of hypotension, and the treatment plan was IV fluids. Interview and record review with the DON on 6/5/2024 at 3:40 PM identified MD #1 should have been contacted regarding Resident #1's critical lab values and was unable to provide an explanation why the physician was not notified timely by the facility staff. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician Notification Policy dated 11/2016 identified the facility will provide or obtain laboratory and other diagnostic services ordered by a physician, physician assistant or nurse practitioner and report results to the physician, physician assistant or nurse practitioner. Although requested, a facility policy for reporting critical lab results was not provided for surveyor review.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for quality of care, the facility failed to ensure IV antibiotics were administered timely in accordance with physician orders. The findings include: Resident #1's diagnoses included methicillin resistant staphylococcus aureus infection, urinary tract infection, dysphagia, and depression. The RCP dated 1/21/2024 identified Resident #1 was receiving intravenous (IV) therapy (Vancomycin) for recurrent UTI's (urinary tract infection). Interventions directed to monitor intake and output every shift, and to administer IV Vancomycin as ordered. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had severely impaired cognition and received IV antibiotics. a. A physician order dated 1/21/2024 directed to administer Vancomycin HCl Intravenous Solution 1500 mg/300 ml, every 18 hours, IV. Review of the January 2024 eMAR (electronic medication administration record) identified the following: 1. Resident #1 received IV Vancomycin on 1/28/2024 at 1:30 PM. The next dose was administered on 1/29/2024 at 9:30 AM. A total of twenty (20) hours between doses; the dose was administered 1 hour late. 2. Resident #1 received IV Vancomycin on 1/29/2024 at 9:30 AM. The next dose was administered on 1/30/2024 at 12:43 AM. A total of fifteen (15) hours and thirteen (13) minutes between doses; the dose was administered one(1) hour and 47 minutes early. Interview with DON on 6/5/2024 at 3:40 PM identified the nursing staff are expected to administer medications according to physician orders within one hour before and after the scheduled time. The DON was unable to explain why the IV medication was not administered in accordance with physician orders. b. Physician order dated 1/30/2024 directed to discontinue Vancomycin IV every 18 hours. A nursing progress note dated 2/5/2024 at 10:31 AM by the ADON identified MD #1 (Infectious Disease physician) called the facility with new orders to discontinue Vancomycin and start Daptomycin IV daily, through 2/11/2024. Review of the February 2023 eMAR failed to reflect that Vancomycin was administered on 2/5/2024. Review of Person #1's photograph identified an empty Vancomycin IV bag on an IV pole labeled with Resident #1's name, the facility name, and Vancomycin 1.24 grams (gm) in 250 ml of normal saline. The directions on the label directed to infuse every 18 hours. The label also had handwritten 2/5 and 1:30 PM on the label indicating the Vancomycin was administered on 2/5/2024 (6 days after the order was discontinued). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADON on 6/5/2024 at 12:45 PM identified Person #1 had alleged Resident #1 received an extra dose of Vancomycin but indicated on the day that Person #1 verbalized the concern, there was an old Vancomycin IV bag that was labeled 2/4/2024 at 8:05 PM (5 days after the Vancomycin was ordered to be discontinued). Interview with DON on 6/5/2024 at 3:40 PM identified although she did not think Resident #1 received an extra dose of IV Vancomycin, the DON was unable to explain the IV bags labeled 2/4 and 2/5/2024. The DON identified nursing staff should administer medications per physician's orders. Although requested, the facility did not provide a policy regarding IV administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for hydration, the facility failed to ensure intake and output was monitored in accordance with physician orders, and failed to perform a dehydration evaluation timely for a resident not meeting their estimated daily fluid needs. The findings include: Resident #1's diagnoses included methicillin resistant staphylococcus aureus infection, urinary tract infection, dysphagia, and depression. A physician order dated 1/20/2024 directed to monitor intake and output (I & O), every shift for 72 hours, upon admission/readmission, and to document on I & O paper flowsheet. Review of Resident #1's Nutrition Evaluation dated 1/20/2024 identified Resident #1's estimated daily fluid needs totaled 1875 milliliters (mls). The care plan dated 1/25/2024 identified Resident #1 as at risk for malnutrition related to severe cognitive changes, variable oral intake, slight weight loss, aspiration risk, and on antibiotics. Interventions directed to monitor oral intake, and lab work as ordered. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had severely impaired cognition and required set up assistance for eating/drinking. Review of the I & O Paper Flowsheet identified the following: The facility failed to provide I & O records for 1/20, 1/21, and 1/22/2024. On 1/20/2024, Resident #1's total intake was 760 ml (1115 ml under the daily recommendation). On 1/23/2024 Resident #1's total intake was 660 ml (1215 ml under the daily recommendation). The facility failed to provide I & O records for 1/25, 1/26, and 1/27/2024. On 1/28/2024, Resident #1's total intake was 180 ml (1695 ml under the daily recommendation). The facility failed to provide I & O records for 1/29, 1/30, 1/31, 2/1, 2/2, 2/3, and 2/4/2024. On 2/5/2024, Resident #1's total intake was 450 ml (11425 ml under the daily recommendation). Interview with DON and ADON on 6/5/2024 at 3:40 PM identified I & O's are entered by any nursing staff, but are tallied/finalized by the night shift nurses. The DON indicated if a resident is not meeting their fluid goal, the nursing staff should notify the physician. The DON stated she was unaware Resident #1 was missing I & O Flowsheets and was unable to explain why the low intake levels were not addressed when Resident #1 did not meet the recommended daily fluid intake. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, the facility was not able to provide the missing I & O Flowsheets for Resident #1. Review of the Intake and Output Monitoring Policy dated 4/2015 identified intake and output will be monitored initially for 72 hours after a resident is admitted or readmitted . Continued monitoring may be required based on the resident's risk factors for dehydration, as outlined in the Hydration Policy, or based on the results of a Dehydration Evaluation, if conducted. a. Interview with DON and ADON on 6/5/2024 at 3:40 PM identified it is not the facility policy to perform a dehydration risk evaluation upon admission. The DON identified the nursing staff utilize other assessment measures (such as assessing skin turgor or mucous membranes) to determine if a resident is a dehydration risk. The DON was unable to explain when Resident #1 did not meet his/her estimated daily fluid needs on 1/20, 1/23, 1/28 and 2/5/2024 why a dehydration assessment was not completed. Review of the facility Hydration Policy dated 4/2015 identified residents identified for potential to be at risk for dehydration will be placed on intake and output monitoring until adequate hydration status is achieved or until I & O monitoring is no longer clinically indicated. If the resident has consumed less than their estimated needs for three (3) consecutive days, complete a Dehydration Evaluation.