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	07/10/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and family interviews, record review, and review of the facility policies titled Baseline Care Plans and Comprehensive Care Plans, the facility failed to ensure that one R (R) (R7) out of eight reviewed for participation in care plan meetings, or R7's Power of Attorney (POA), were invited to participate in the care plan meetings to ensure that the care plan was individualized to meet R7's personal goals and preferences. Findings include: Review of facility policy titled Baseline Care Plan, revised 6/2025, revealed the Guidelines section included . 6. Within 48 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. 7. Document evidence of the summary given to the resident or their representative in the medical record. Review of facility policy titled Comprehensive Care Plans, revised 3/2025, revealed the Guidelines section included 1. The facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 12. Provide the resident and their representative a copy of the current care plan or a summary.Review of the admission Record for R7 revealed he was admitted to the facility on [DATE] and diagnoses included, but were not limited to, asthma and end-stage renal disease.Record review of the Minimum Data Set (MDS) Quarterly assessment, dated 8/21/2024, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) of 11 (indicating moderate cognitive impairment).Review of R7's electronic medical record (EMR) attached under the Miscellaneous Documents a document titled Care Plan Conference Summary, dated 1/30/2025, revealed there was no indication that the resident or POA were invited to or attended the care plan meeting. Review of R7's EMR attached under the Miscellaneous Documents a document titled [Resident's name] Baseline Care Plan dated 5/29/2025 Section Q Signatures and Acknowledgement revealed no indication that R7 or the family of R7 attended, signed, or was given a copy of the resident's care plan. In a telephone interview on 7/2/2025 at 2:31 pm with R7's POA, who is a family member, stated that the family was concerned about the care and services R7 was receiving. The POA stated the family wanted to participate in R7's plan of care. The POA further stated he had placed calls to the facility and left messages, requesting that someone return the call so that a care plan meeting could be scheduled. The POA stated the facility never returned any of the calls. In an interview on 7/2/2025 at 3:27 pm, the Clinical Reimbursement Coordinator (CRC) CC stated that the residents were invited to the care plan meeting via a letter that was delivered to the resident. CRC CC stated there was no need to invite the POA/Family to the care plan meeting for R7. The CRC stated that R7 was his own responsible party, and families were only invited if the resident requested it.In an interview on 7/2/2025 at 4:30 pm, the Administrator stated that the resident, as well as the family/Responsible Party (RP)/POA, should be invited to the care plan meetings. The Administrator stated he educated the Interdisciplinary Team (IDT) by reviewing the federal guidelines related to inviting the resident/families/RP/POA to the care plan meetings.

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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** Based on family and staff interviews, and record reviews, the facility failed to notify the Power of Attorney (POA)/family of a change in condition of one resident (R) (R7) of eight residents reviewed for notification of change. Findings include:Review of the admission Record for R7 revealed he was admitted to the facility on [DATE] and diagnoses included, but were not limited to, asthma and end-stage renal disease. Further review of the admission Record revealed one person was listed as R7's POA and two people were listed as emergency contacts.Record review of R7's Minimum Data Set (MDS) Quarterly assessment, dated 8/21/2024, revealed that a Brief Interview for Mental Status (BIMS) was assessed at eleven (indicating moderate cognitive impairment).Review of a Nursing Skilled Note, dated 6/26/2025, revealed R7 was observed vomiting {sic} coffee ground- like emesis, in house nurse practitioner notified and assessed resident. Recommended that the resident be sent out to the hospital for further management. Emergency Medical Service (EMS) was contacted, and the resident was transferred to the hospital at 10:15 am, accompanied by EMS personnel. Resident was stable at the time of transfer. Family was contacted, however there was no answer.In a telephone interview on 7/2/2025 at 2:31 pm with R7's family member, who is the POA, the family member stated they were unaware that R7 had been sent out to the hospital on 6/26/2025 and remained in the hospital. In an interview on 7/2/2025 at 3:23 pm, the Unit Manager DD stated the nurse should have made a follow-up call to the family. She stated that if the nurse could not contact the family, it should have been passed to the next shift. In an interview on 7/8/2025 at 10:36 am, the Social Service Director (SSD) stated that R7 remained in the hospital.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policies titled Grievance/Complaint Log and Lost and Found, the facility failed to make a prompt effort to file a grievance for two of eight sampled residents (R) (R7 and R8) who verbally reported grievances. This deficient practice had the potential to place residents at risk of not having their grievances resolved in a timely manner. Findings include:Review of the facility policy titled Grievance/Complaint Log, with a review date of 10/2024, revealed Policy Statement: The disposition of all resident grievances and/or complaints will be recorded on our facility's Resident Grievance/Complaint Log. Policy Interpretation and Implementation: 1. The disposition of all written grievances and/or complaints must be recorded on the Resident Grievance/Complaint Log.Review of the policy titled Lost and Found, with a review date of 10/2024, revealed Policy Statement: Our facility shall assist all personnel and residents in safeguarding their personal property. Policy Interpretation and Implementation: Resident or family complaints of missing items should be reported by such staff member to the Social Services Director or, in their absence, Manager on Duty. An investigation of such will begin, and the resident or responsible party will be informed of the outcome in 5 days.1. Review of the admission Record for R7 revealed he was admitted to the facility on [DATE], and diagnoses included, but were not limited to, asthma and end-stage renal disease. Record review of the Minimum Data Set (MDS) Quarterly assessment, dated 8/21/2024, revealed a Brief Interview for Mental Status (BIMS) assessed at 11 (indicating moderate cognitive impairment).Review of a Nursing Skilled Note, dated 2/28/2025, revealed R7 dropped his pouch with his cellphone and wallet in it at some point during or after dialysis. Dialysis, maintenance, and nursing staff all looked for the pouch. The nurse placed a call to the family. The family provided R7 cell phone number to the facility. The family was informed the facility will call the cell number to locate the phone.Review of the Grievance Log from 1/23/2025 to 6/26/2025 revealed no documented grievances filed for R7. The surveyor requested any facility reportable incident (FRI) filed by the facility for R7. No FRI was provided to the surveyor.In an interview on 7/2/2025 at 2:31 pm, R7's family, who is also the Power of Attorney (POA), stated he spoke with R7 at least twice a week. The POA stated the last time R7 called from the cell phone was on 2/25/2025. The POA stated a call was received from R7 in February 2025, and the resident (R7) called from the nurse's station. The POA stated the resident stated he was missing a wallet and cell phone. The POA stated he/she spoke with a staff member who confirmed that the wallet and phone were missing, and the facility was trying to locate the phone and wallet. The POA stated that the family sent R7 a new wallet that included fifty dollars in one-dollar bills and a cell phone. He stated that soon after, R7 called again and stated the wallet, money, and cell phone that were sent were missing. The POA stated he did make calls to the facility and left messages that were not returned.2. Review of the admission Record for R8 revealed she was admitted to the facility on [DATE] and diagnoses included, but were not limited to, essential (primary) hypertension and chronic kidney disease.Record review of the MDS Quarterly assessment, dated 6/29/2025, revealed a BIMS assessed at 15 (indicating little to no cognitive impairment).Review of the Grievance Log from 1/23/2025 to 6/26/2025 revealed R8 filed one grievance on 1/27/2025, regarding being bathed with an undesirable water temperature. There were no other documented grievances for R8.During an interview and observation on 7/2/2025 at 11:16 am, R8 was lying in bed with two blankets pulled up to her chin. The resident stated she was cold, and the room's air conditioner was always on high. R8 stated that she has made many complaints to anyone who will listen about the temperature of the room. She stated the staff would adjust the temperature, but if the roommate complained, the temperature would be readjusted. She stated she had also complained of the slow response to answering the call light. R8 stated she had also verbalized the complaints to the Unit Manager.In an interview on 7/3/2025 at 12:08 pm, Social Service Director (SSD) AA stated she was responsible for tracking the grievances on the Grievance Log form. The SSD revealed anyone can complete a Complaint/Grievance Report form. She stated a grievance can be filed verbally or in writing. After the Complaint/Grievance Report form is completed, a copy of the grievance is given to the appropriate department to investigate. The department will return the grievance form to the Social Service Department, indicating if it was resolved and if the person filing the grievance is satisfied with the outcome. The grievances must be resolved within 5 to 7 days. The SSD stated the Administrator was not required to sign off on the grievances. The SSD stated she was not aware that R7 was missing a phone and wallet. She further stated she was not aware that R8 was having problems with the room temperature or the slow