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	10/31/2024

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44757 Based on observations, staff and resident interviews, record review, and review of the facility's policy titled, Confidentiality and Privacy Information, the facility failed to ensure the privacy for one of 30 residents (R) (R98) was maintained by displaying a sign on the bedroom wall disclosing protected personal information. Findings include: A review of the facility's policy titled Confidentiality and Privacy Information, effective date of 10/2023 under the Policy Statement revealed, Our facility shall treat all resident information confidentially. The resident has a right to personal privacy and confidentiality of his or her personal medical record. Review of R98's quarterly Minimum Data Set (MDS) dated [DATE] revealed, for Section B (Hearing, Speech, Vision), indicated the resident's vision was highly impaired; Section C (Cognitive Patterns), a Brief Interview of Mental Status (BIMS) of 15 which indicated little to no cognitive impairment. Observation on 10/27/2024 at 5:24 pm in the room of R98 revealed, a sign above the bed stating visually impaired. Interview on 10/27/2024 at 5:24 pm with R98 revealed, he was unaware of the sign above the bed when asked about it. Interview on 10/30/2024 at 4:21 pm with Certified Nursing Assistant (CNA) BB revealed most of the time the nurses would let them know of any diagnoses and tell them how to care for residents. CNA BB revealed she would ask the nurse or the unit manager if she forgot what to do for the resident and had access to the resident's Plan of Care (POC) on the computer. Interview on 10/30/2024 at 3:49 pm with Licensed Practical Nurse (LPN) FF revealed, she had received trainings related to dignity, privacy and how to treat residents with respect. LPN, FF revealed, if she saw the sign, she would have removed it. She further revealed, if the resident was alert enough, she would speak to them to let them know why she removed it. Interview on 10/30/2024 at 5:38 pm with the Administrator revealed they did not know the sign was there and it was not their expectation for anything with private information to be posted on the resident's wall.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER: Meadowbrook Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 4608 Lawrenceville Highway Tucker, GA 30084	

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident’s representative in writing how long the nursing home will hold the resident’s bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47946 Based on staff interviews, record review, and review of the facility's policy titled, F 625 Bed Hold, the facility failed to ensure a bed-hold policy upon transfer to the hospital for one of two residents (R) (R27) reviewed for hospitalization s. Findings include: Review of the facility policy titled F 625 Bed Hold revised May 2023 revealed, 1. Upon admission and when a resident is transferred for a non-emergency hospitalization or for therapeutic leave, a representative of the business office will provide information concerning our bed-hold policy. 2. When emergency transfers are necessary, the facility will provide the resident and the resident representative with information concerning our bed-hold policy per state law as applicable. Review of R27 clinical records revealed, the resident admitted to the facility with diagnoses that included but not limited to chronic kidney disease, acute on chronic systolic (congestive) heart failure, chronic obstructive pulmonary disease, unspecified, acute respiratory failure, and diabetes mellitus. Review of R27's Physician orders revealed an order for torsemide oral tablet 40 milligrams (mg), ipratropium-albuterol inhalation solution 0.5-2.5 (3) (mg)/3 milliliter (ml), Trelegy Ellipta inhalation aerosol powder breath activated 200-62.5-25 micrograms/ante cibum (mcg/ac), and oxygen (O2) at 4 (four) liters per minute (L (liters)/min [minute]) via nasal cannula to maintain O2 at or above 92% continuously every shift. Review of R27's most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed, Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had little to no cognitive impairment. Interview on 10/31/2024 at 11:10 am with Licensed Practical Nurse (LPN) AA revealed, Registered Nurse (RN) GG was the night supervisor in charge, and she sent R27 to the hospital on 10/27/2024 due to edema. LPN AA confirmed that RN GG did not complete the proper paperwork for the Business Office Manager (BOM) to create a copy of the bed hold. Interview on 10/31/2024 at 11:20 am with the BOM revealed that a bed-hold policy was given upon admission in the admission packet. She indicated she was responsible for issuing the bed hold paperwork to the residents that were transferred to the hospital. She revealed normally the nurse put the transfer in a green folder at the nursing station for her to process the bed hold forms. She confirmed R27 did not receive any bed hold paperwork upon transfer to the hospital on 6/9/2024, 8/11/2024, and 10/27/2024. She stated, the main reason bed hold policies do not get issued to the residents was because it's a break in our process. (continued on next page)

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Meadowbrook Health and Rehab	4608 Lawrenceville Highway Tucker, GA 30084

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/31/2024 at 11:30 am with the Administrator and Director of Nursing (DON) confirmed it was the responsibility of the nursing staff to get the information to the BOM in a timely matter to properly issue bed hold policy forms to all residents or their responsible party who were being transferred to the hospital. DON stated they also have an encrypted phone app that allows them to communicate over the weekends. Telephone Interview on 10/31/2024 at 1:30 pm with RN GG confirmed she did not give the bed hold paperwork to the BOM. She stated, I did not know to do a bed hold, and have not receive any training on the proper steps regarding bed holds. I only know about doing assessments and that is what I did for her.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50374 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, Comprehensive Care Plan, the facility failed to develop a care plan specific to the recommendations per the physician's order related to the pain scale for one resident (R) (R23), failed to develop a care plan for dialysis for R64, and failed to to follow and update the care plan for refusals on restorative care for R19. The sample size was 30 residents. Findings include: Review of the facility's policy titled, Comprehensive Care Plan dated August 2024 revealed, An individualized comprehensive person-centered care plan that includes measurable objective and time frames to meet the resident's medical, nursing, mental, cultural and psychological needs is developed for each resident. Further review of the policy revealed, (1) The facility's Care Planning/Interdisciplinary Team (IDT), 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 maybe expected to attain. (2) The comprehensive care plan is based on a thorough assessment that includes but is not limited to Minimum Data Set (MDS) and physician's orders. Assessment of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. (3) The Care Planning/IDT is responsible for the periodic review and updating of care plans: (a) When there has been a significant change in the resident condition. 1. Review of clinical records revealed R23 was admitted to the facility on [DATE] with diagnoses that included fracture of left lower leg sequela, and displaced trimalleolar fracture of unspecified lower leg, initial encounter for closed fracture. Review of the most recent quarterly Minimum Data Set (MDS) dated [DATE] revealed for Section C (Cognitive Patterns) R23 had a Brief Interview of Mental Status (BIMS) score of 14 indicating little to no cognitive impairment. Review of R23's care plan dated for 10/9/2024 revealed there was not a care plan for opioid medication and management. Review of the physician's order dated 10/15/2024 documented tramadol (narcotic) hydrochloric (HCL) oral tablet (tab) 50 milligrams (MG). Directions: Give tablet mouth every eight hours as needed for severe pain (pain level 7-10.) Review of the Physicians order dated 10/15/2024 documented hydrocodone-acetaminophen (acet)(narcotic) 7.5-325 tab {100 each (ea)} Directions: Give one ablet by mouth every four hours as needed for moderate pain (pain level 4-6). Review of the Physicians order dated 8/22/2024 documented Fentanyl (opioid) patch 72 hours 23 (micrograms) MCG /hour (hr) Directions: apply one patch topically every 72 hours. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 10/30/2024 at 1:24 pm, with R23 revealed she was aware and involved in her care plan meetings. She stated that her care plans should address the medication she has ordered. Interview on 10/30/2024 at 1:36 pm with Licensed Practical Nurse (LPN) AA revealed care plans were done on all residents quarterly related to their medication and treatment. She further stated if there were any concerns that needed to be addressed the staff should report this to her and she would report the concerns to the Nurse Practitioner (NP). After the concerns were reported she would assess the resident herself and a change of condition should take place. Interview on 10/30/2024 at 4:08 pm with LPN FF revealed she was able to update the care plan herself. She revealed, the MDS staff were involved in addressing concerns for the residents and would have a team meeting to implement interventions if needed. She continued to state if there was something incorrect, she would go to the MDS team to be corrected. Interview on 10/30/2024 at 4:21 pm with MDS CC and MDS DD staff both revealed, they were responsible for updating the care plan. They stated the care plan meetings involve the nurses and the IDT team, and they record the information that was being obtained in the meetings. MDS CC stated the medical part of the care plan was completed by the nurses. Further interview with MDS DD revealed the staff collaborate on the MDS part and the IDT team can do the medication portion of the MDS. They further stated the nurses should let them know if things need to be updated or have changed. Lastly, MDS CC and MDS DD both confirmed they do not look at any assessment as they are putting together the residents care plans. Interview on 10/30/2024 at 5:48 pm with the Director of Nursing (DON) confirmed the MDS team handles completing and updating the care plans. She stated they headline the care plan, and the nurses were able to update as needed. She continued to confirm the MDS staff were the ones who can input specific information into the care plans. 44757 2. Record review of R64's Admission MDS assessment dated [DATE] revealed, for Section C (Cognitive Patterns), a BIMS of 12 which indicated little to no cognitive impairment, Section I (Active Diagnosis) revealed, dependence on renal dialysis, acute kidney failure, unspecified and disorder of kidney and ureter, unspecified. Review of the comprehensive care plans for R64 revealed she did not care have a care plan for receiving dialysis. Observation on 10/27/2024 at 5:04 pm of R64 revealed, she had a port in her chest. Interview on 10/27/2024 with R64 revealed she received dialysis and went to dialysis in house on Mondays, Wednesday and Fridays during the mornings. Interview on 10/30/2024 at 5:08 pm with MDS DD revealed both coordinators were responsible for updating the care plans, but the nurses were able to as well or anyone on the IDT can update. She confirmed that R64 had not been care planned for dialysis and that it was an oversight. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/30/2024 at 5:34 pm with the DON revealed it was the expectation for MDS to handle the updates of the care plan. 3. Review of the Electronic Medical Record (EMR) revealed R19 was admitted to the facility on [DATE] with the diagnoses of but not limited to hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominant side. Review of R19's quarterly MDS assessment dated [DATE] revealed for Section C (Cognitive Patterns) a BIMS score of 5 (five) indicating severe cognitive impairment, Section GG (Functional Abilities and Goals) impaired upper extremity mobility on one side, and lower extremity impairment on one side, mobility by way of wheelchair, Section O (Special Treatments, Procedures, and Programs),Speech Language Pathologist (SLP) start 4/4/24-7/5/2024, Occupational Therapist (O/T) 6/10/2024-9/6/2024, Physical Therapy (P/T) 4/4/2024-6/20/2024. Review of R19's care plan dated 9/22/2024 revealed a focus: ROM or improve resident range of motion (ROM). Contracture to Right arm and hand. Goal: Resident will maintain or improve mobility through next assessment period. Interventions: Put towel or roll in R19's right hand to maintain skin integrity. Provide R19 with an active range of motion per therapy or nursing assessment. OT to evaluate and treat per order. Further review of care plans revealed, there was no care plan written for the resident's refusal to wear his splint. Review of the document titled Occupational Therapy Discharge Summary dated 6/10/2024 - 9/6/2024 revealed a discharge summary that patient will wear grip splint on right hand for up to 4.5 hours with minimal signs/symptoms of redness, swelling, discomfort or pain. Interview on 10/30/2024 at 10:50 am with LPN FF revealed, stated should apply the splint to the resident's hand if no restorative person was present to do it. She said sometimes he refuses to have his splint applied. Interview on 10/30/2024 at 5:08 pm with MDS CC and MDS DD revealed they are both responsible for updating the residents MDS's, but the nurses and the IDT update the care plans at the meetings. She revealed, the MDS Nurse was responsible for the assessment, and the care plan conferences, but the staff could modify or resolve anything on the care plan. She revealed they assist the CNAs to find things they may need related to the care plan. She said the staff can see the interventions as well. She said the nurse should let them know if things are to be updated or have been updated. She confirmed they were responsible for keeping the care plans updated.

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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** 50374 Based on observation, resident and staff interview, record review, and review of the facility's policy titled, Administering Medication the facility failed to follow the physician's orders as recommended for one of 30 residents (R)(R23). Findings include: Review of the facility's policy titled, Administering Medication dated October 2024 documented Medications shall be administered in a safe and timely manner, and as prescribed. (3) Medications must be administered in accordance with the orders, including required time frame. R23 was admitted to the facility on [DATE] with a diagnosis that includes fracture of left lower leg sequela, and displaced trimalleolar fracture of unspecified lower leg, initial encounter for closed fracture. Review of the most recent quarterly MDS dated [DATE] documented R23 had a Brief Minimum Data Set (BIMS) score of 14 indicating little to no cognitive impairment. Further review revealed R23 had no behavior exhibited and requires a four-person mechanical lift, and assistance with activities of daily living (ADLs). Review of the care plan dated for 10/9/2024 revealed there is not care plan for opioid medication and management. Review of the Physicians order dated 10/15/2024 documented tramadol (narcotic) hydrochloric (HCL) Oral Tablet (tab) 50 milligrams (MG). Directions: Give tablet mouth every eight hours as needed for severe pain (pain level 7-10). Review of the Physicians order dated 10/15/2024 documented hydrocodone-acetaminophen (acet)(narcotic) 7.5-325 tab {100 each (ea)}. Directions: Give one ablet by mouth every four hours as needed for moderate pain (pain level 4-6). Review of the Physicians order dated 8/22/2024 documented FentaNYL (opioid) patch 72 hours 23 (micrograms) MCG /hour (hr). Directions: apply one patch topically every 72 hours. Interview and observation on 10/20/2024 at 1:24 pm with R23 revealed she is aware on the three medications she is taking along with the pain scale for each medication. She stated she request her pain medication and tells the nurses what narcotics she wants and along with the pain level she is having. She confirmed she asked for hydrocodone often even though it is not within the pain scale that is recommended per her physicians. Review of the Medication Administration Record (MAR) dated for October documented: Hydrrocodone-acet given October 1 with a pain level of 8. Hydrrocodone-acet given October 2 with a pain level of 7. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydrrocodone-acet given October 3 with a pain level of 8 and 7. Hydrrocodone-acet given October 4 with a pain level of 8. Hydrrocodone-acet given October 5 with a pain level of 8 and 7. Hydrrocodone-acet given October 6 with a pain level of 8. Hydrrocodone-acet given October 7 with a pain level of 7. Hydrrocodone-acet given October 8 with a pain level of 9. Hydrrocodone-acet given October 9 with a pain level of 8. Hydrrocodone-acet given October 10 with a pain level of 8. Hydrrocodone-acet given October 13 with a pain level of 7. Hydrrocodone-acet given October 14 with a pain level of 8. Hydrrocodone-acet given October 15 with a pain level of 7. Hydrrocodone-acet given October 16 with a pain level of 7. Hydrrocodone-acet given October 18 with a pain level of 7. Hydrrocodone-acet given October 22 with a pain level of 7. Hydrrocodone-acet given October 24 with a pain level of 8. Tramadol given on October 4 with a pain level of 4 and 5. Tramadol given on October 12 with a pain level of 5. Tramadol given on October 13 with a pain level of 6. Tramadol given on October 22 with a pain level of 6. Tramadol given on October 26 with a pain level of 6. Tramadol given on October 27 with a pain level of 6. Interview on 10/30/2024 at 1:36 pm with Licensed Practical Nurse (LPN) AA stated because R23 is aware of her pain ans she'll usually lets the staff know the pain level she is having and the medication she would like to take. LPN AA continued to state she does ask for pain medication often but is not a seeker. She stated she contacts the nurse practitioner (NP) and physicians if she believes R23 needs an adjustment to her medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/30/2024 at 1:50 pm with the Director of Nursing (DON) revealed the staff are supposed to operate according to the physician's order. If there are any changed that need to be made the staff are expected to call the physician for specific orders that need to take place. She continued to confirm the physician's orders, and the Medication Administer Record (MAR) should align. Interview on 10/30/2024 at 5:45 pm with the Administration confirmed all nurses should follow the medical doctor orders as prescribed.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48338 Based on observations, interviews, record review and review of the facility's policy titled Goals and Objectives, Restorative Services and Rehabilitative Nursing Care the facility failed to provide a right-hand grip splint for up to 4.5 hours for one of one Residents (R19) reviewed for rehab and restorative. Findings include: Review of the facility's policy titled Goals and Objectives, Restorative Services last reviewed 10/2024 revealed the policy was specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessments. Under the Policy's Guidelines section revealed, Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. 2. (b) Assisting the resident in developing and strengthening his/her physiological and psychological resources. 2. (c) Encouraging the residents to maintain his/her independence and self-esteem. Review of the facility's policy titled Rehabilitative Nursing Care last revised 10/2024 under the Policy's Interpretation and Implementation revealed, 1. General rehabilitative nursing care is that which does not require the use of Qualified Professional Therapist to render such care. 2. Nursing personnel are trained in rehabilitative nursing care, and our facility has an active program of rehabilitative nursing which is developed and coordinated through the residents' care plan. 3. The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. Review of the Electronic Medical Record (EMR) revealed R19 was admitted to the facility on [DATE] with the diagnoses of but not limited to hemiplegia and hemiparesis following cerebrovascular disease affecting the right dominant side. Review of R19's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Section GG (Functional Abilities and Goals) impaired upper extremity mobility on one side, and lower extremity impairment on one side, mobility by way of wheelchair, Section O (Special Treatments, Procedures, and Programs),Speech Language Pathologist (SLP) start 4/4/24-7/5/2024, Occupational Therapist (O/T) 6/10/2024-9/6/2024, Physical Therapy (P/T) 4/4/2024-6/20/2024. Review of the document titled Occupational Therapy Discharge Summary dated 6/10/2024 - 9/6/2024 revealed a discharge summary that patient will wear grip splint on right hand for up to 4.5 hours with minimal signs/symptoms of redness, swelling, discomfort or pain. Review of the document titled [Name of Facility] Follow Up Question Report dated 10/23/2023-12/22/2023 Restorative Nursing revealed, Resident to tolerate Right grip splint 2 hours or better with minimal pain six/week for 12 weeks. There were no other weekly Restorative notes from the Restorative Certified Nursing Aide nor monthly notes from the Supervisors of Restorative Nursing Care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the document titled Restorative Nursing Program Recommendations dated 9/29/2024 revealed OT recommendations for resident to tolerate right grip splint five hours to maintain current level of function (CLOF). Review of the document titled Plan of Care (POC) Response History dated 10/30/2024 revealed a mobility device task with all No responses checked from 10/17/2024- 10/30/2024. Observation on 10/27/2024 at 2:45 pm of R19 in the day area revealed, the resident's right hand was very contracted, and his fingernails were touching the inside of his hand. R19 was not wearing a splint on his right hand. Observation and Interview on 10/28/2024 at 4:56 pm with R19 revealed he did not have a splint on his right hand. R19 right hand was turned inward with his fingers touching his hand. When asked about his splint, R19 went to his drawer and opened it where the splint was observed inside his drawer. Observation on 10/29/2024 at 12:43 pm of R19 revealed, he was not wearing a splint on his right hand. Further observation revealed, the splint was in his drawer at bedside. Interview on 10/29/2024 at 1:15 pm with MDS, CC and MDS, DD revealed, they should document on the resident for 12 weeks six times per week. They said his order possibly fell off, and they stopped the documentation. They said they could ask PT/OT to pick him up or flag the order for restorative to do the task and document. When asked if there was any documentation to support the times that he wore the splint they said they would look through the system for it. During a follow up interview at 4:30 pm, they returned with documentation of the splint from 10/23/2023 to 12/4/2023 and confirmed there was no documentation for R19 wearing the splint this year. Interview on 10/30/2024 at 10:50 am with Licensed Practical Nurse (LPN), FF revealed that staff should apply the splint to the resident's hand if no restorative person was present to do it. She said sometimes he refused to have his splint applied. She went to ask the Certified Nursing Assistant (CNA) HH if she had applied the splint to the resident's right hand, and she returned and reported that the staff member had applied the splint. Interview on 10/30/2024 at 11:00 am with CNA, HH revealed she did apply the splint to the resident's right hand. She said she saw the splint lying on the resident's nightstand and applied it. Interview on 10/30/2024 at 11:10 am with LPN, Unit Manager (UM), II revealed she had educated the staff on yesterday 10/29/2024 regarding applying splints all shifts, on residents with orders. She said she informed them it was to be documented in the EMR under task, and document change of positions as well. She said she informed them that the task tab shows who gets it, where it was applied, and if they refuse it. She said they were to notify Therapy if it was applied or not, and if the resident refuses, it was to be documented. They should also document applying and removal times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/31/2024 at 10:35 am with the Director of Nursing (DON) revealed her expectations for the Supervisors overseeing the Restorative Team was to take care of the residents according to the orders, applying splints, walking, etc. She said she would follow through and make sure that each resident was receiving daily restorative care as ordered. She said she would ensure that information was gathered from Physical Therapy (PT) and is communicated with the Medical Doctor, Nurses and UMs. She said she expects the residents to receive the care that they deserve and ordered to receive. She said the MDS Nurse was over restorative, and each part of the nursing team was responsible for ensuring the resident on the unit receives restorative care even though there was a restorative team. She said they are to reach out and follow up if their residents have not received their restorative care. She said she expects the restorative Supervisors to communicate with PT to coordinate care of the residents receiving restorative care during therapy and at discharge to prevent omitting new orders.

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	10/31/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49138 Based on observations, staff interviews, record review, and review of the facility's policy titled Oxygen Administration, the facility failed to administer oxygen (O2) as ordered for one of two residents (R) (R9) reviewed for respiratory care. Findings include: Review of the facility's policy titled Oxygen Administration with effective date of 4/2024 under the section titled, Purpose revealed, The purpose of this procedure is to provide guidelines for safe oxygen administration. Under the section Preparation revealed, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Under the section, Documentation revealed, After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record:1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. Review of R9's Electronic Medical Records (EMR) revealed R9 had diagnoses that included but not limited to chronic systolic congested heart failure (CHF), pleural effusion, chronic obstructive pulmonary disease (COPD), and acute and chronic respiratory failure. Review of R9's Minimum Data Set (MDS) dated [DATE] revealed Section C - Cognitive Pattern-a Brief Interview of Mental Status (BIMS) score of 15, which indicated little to no cognitive impairment; Section I - Active Diagnoses -Anemia, Heart failure, Asthma (COPD) & Respiratory failure; and Section O - Special Treatments, Procedures, and Programs-Oxygen therapy. Review R9's physician orders dated 10/1/2024 revealed, O2 at 2 LPM (liters per minute) via nasal cannula. Observation on 10/27/2024 at 3:37 pm revealed, R9 oxygen was flowrate was set at 3 LPM via nasal cannula. Observation on 10/28/2024 at 1:40 pm revealed, R9 oxygen flow level was set at 3.5 LPM via nasal cannula. Interview on 10/28/2024 at 2:02 pm with License Practical Nurse (LPN) AA confirmed R9 oxygen orders were 2 LPM and the oxygen in R9 room was set at 3.5 LPM. Interview on 10/28/24 at 2:44 pm with Director of Nursing (DON) revealed her expectations of staff to follow orders recommended by the physician. DON stated if a resident the oxygen is set at a higher level there could be an adverse effect depending on the residents' medical condition.