STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115604	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brown's Health & Rehab Center	226 South College Street Statesboro, GA 30458

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41165 Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Administration Guidelines, the facility failed to ensure that two residents (R) (R1 and R2) were protected from not following physician orders. Actual harm occurred when pain medication with sedative effects was administered to R1 and R2, which caused them to become lethargic and hard to arouse on 3/6/2024, resulting in both residents being transferred to the emergency room (ER) and treatment with Narcan (reverses an opioid overdose). R1 was admitted with a diagnosis of somnolence (drowsiness), and R2 returned to the facility, declining admission to the hospital. Findings include: A review of the Medication Administration Guidelines, dated January 2018, Purpose: The purpose of these guidelines is to promote the health and safety of the residents we serve by ensuring the safe assistance and administration of medications and treatments. Monitoring: Assessing and evaluating the resident's responses to medication therapy and monitoring residents for adverse drug reactions. A. General procedures completed before administering medication by any route: a. The resident's Medication Administration Record (MAR) is reviewed to determine what medications are to be administered, and then staff removes those medications from the medication cart. c. Staff will compare the MAR with the label of each medication for the following: i. Right Person, ii. Right Medication, iii. Right Date, iv. Right Time, v. Right Route, vi. Right Dose, vii. Expiration Date. 1. Record review of the most recent Medicare -5 Day Minimum Data Set (MDS) for R1, dated 3/5/2024, revealed a Brief Interview for Mental Status (BIMS) score of 7 (a BIMS score between 0 and 7 indicated severe cognitive impairment). Record review revealed R1 had a physician order with a start date of 3/4/2024 for oxycodone (treats moderate to severe pain) hydrochloride (HCl) 5 (milligrams) mg to be administered by mouth every six hours as needed (PRN) for severe pain. Record review of the Medication Administration Record (MAR) for R1 dated 3/5/2024, documented the following: oxycodone 5 mg was administered at 4:05 pm. A review of R1's Controlled Substance Proof of Use Form revealed the following documentation: oxycodone HCL 5 mg was signed out and administered on 3/5/2024 at 4:00 pm by the 6 am-6 pm nurse. And then signed out by Licensed Practical Nurse (LPN) AA, the 6 pm-6 am nurse, at 6:00 pm. The 6 pm dose was administered two hours after the 4:00 pm dose was administered. (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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(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 - Actual harm Residents Affected - Few	A review of R1's Progress Notes dated 3/6/2024 at 9:28 am revealed the resident received multiple doses of oxycodone 5 mg for pain to left hip. Medical Director (MD) was notified. A new order is to administer Narcan 4 mg nasal spray; after 5 minutes, if not effective, administer 2nd dose and send to hospital for evaluation. 1st dose administered at 9:30 am, and a 2nd dose administered at 9:37 am; R1 was sent to the hospital. 2. Record review of the most recent Medicare - 5 Day MDS for R2 dated 3/8/2024 revealed a BIMS score of 14 (a BIMS score between 13 and 15 indicated cognition is intact). Record review revealed R2 had a physician order with a start date of 3/4/2024 for oxycodone HCL 10 mg to be administered by mouth every six hours as needed for pain. A review of the MAR for R2 dated 3/5/2024 documented the following: oxycodone 10 mg was administered at 3:08 pm. A review of R2's Controlled Substance Proof of Use Form revealed the following documentation: oxycodone HCL 10 mg was signed out and administered on 3/5/2024 at 3:00 pm by the 6 am-6 pm nurse. And then signed out by LPN AA, the 6 pm-6 am nurse, at 6:00 pm. The 6 pm dose was administered three hours after the 3:00 pm dose was administered. A review of R2's Progress Notes dated 3/6/2024 at 9:29 am revealed the resident received multiple doses of oxycodone 10 mg for generalized body pain. MD was notified, and a new order was to administer Narcan Nasal Spray 4 mg. The first dose of Narcan at 9:29 am in the left nostril. A review of R2's Progress Notes dated 3/6/2024 at 10:55 am revealed the resident had a fall, the MD was notified, and the resident was sent to the hospital for evaluation. Interview on 3/12/2024 at 8:30 am with the Director of Nursing (DON) revealed that on the morning of 3/6/2024 a Registered Nurse (RN) was making rounds on A Hall and noted that two residents were more lethargic than usual. She then reported what she had observed to the DON and the Unit Managers, they proceeded to assess the two residents in question (R1 and R2) by completing vital signs and assessing pupil reaction, which was sluggish for both residents. When the DON reviewed the narcotic sheets for the residents, it was noted that both residents had been given oxycodone within two-three hours of their last dose and then two more times during LPN AA's 6 pm - 6 am shift. The resident's physician was notified and orders to administer Narcan to the residents were received. R1 was given one dose and was aroused and R2 received two doses two hours apart. R1 was sent to the hospital, where she was admitted for somnolence (drowsiness) and did not return to the facility. R2 had a fall later that morning after the two doses of Narcan, was sent to the ER, and returned to the facility. Further interview with the DON revealed that LPN AA was suspended pending an investigation, and a report to the State Agency was completed. LPN AA was terminated and did not return any phone calls to the DON regarding this incident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/8/2024 at 12:57 pm with the DON revealed that LPN AA was the only nurse signing off on PRN pain medication and stated that she educated LPN AA regarding medication administration. The DON stated that pain assessments are done every shift. The DON revealed that the LPN AA was not documenting effectiveness from pain medication. She stated that she wasn't consistently signing off on the MAR, but she did sign out on the narcotic sheet. During the continued interview, the DON revealed that after the in-service, LPN AA continued to be inconsistent signing out narcotics on the MAR. The DON stated that she did not specifically meet with her again and re-educate her. The DON stated that LPN AA, who worked the night shift went home and refused to talk over the phone and refused to come in and discuss the incident.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41165 Based on observations, staff interviews, record review, and review of the facility's policy titled Medication Administration Guidelines, the facility failed to ensure that two residents (R) (R1 and R2) were free of a significant medication error. Actual harm occurred when pain medication with sedative effects was administered to R1 and R2, which caused them to become lethargic and hard to arouse on 3/6/2024, resulting in both residents being transferred to the emergency room (ER) and treatment with Narcan (reverses an opioid overdose). R1 was admitted with a diagnosis of somnolence (drowsiness), and R2 returned to the facility, declining admission to the hospital. Findings include: A review of the Medication Administration Guidelines, dated January 2018, revealed the Purpose: The purpose of these guidelines is to promote the health and safety of the residents we serve by ensuring the safe assistance and administration of medications and treatments. Definitions: Transcribing: Ensuring accurate transcription and documentation of medications from physician telephone orders, faxed orders, etc. Dispensing: Communicating with pharmacy to ensure accurate and timely delivery of medications. Administering: safe administration of large volumes of medications within time constraints. Monitoring: Assessing and evaluating the resident's responses to medications therapy and monitoring residents for adverse drug reactions. The resident's Medication Administration Record (MAR) is reviewed to determine what medications are to be administered, and then staff removes those medications from the medication cart. c. Staff will compare the MAR with the label of each medication for the following: i. Right Person, ii. Right Medication, iii. Right Date, iv. Right Time, v. Right Route, vi. Right Dose, vii. Expiration Date. 1. Record review of the Electronic Medical Record (EMR) revealed R1 was admitted to the facility on [DATE] with diagnoses of cellulitis of the groin, urinary tract infections, pain unspecified. Record review revealed R1 had a physician order with a start date of 3/4/2024 for oxycodone (treats moderate to severe pain) hydrochloride (HCl) 5 (milligrams) mg to be administered by mouth every six hours as needed (PRN) for severe pain. A review of R1's Controlled Substance Proof of Use Form revealed the following documentation: oxycodone HCL 5 mg was signed out and administered on 3/5/2024 at 4:00 pm by the 6 am-6 pm nurse. And then signed out and administered by Licensed Practical Nurse (LPN) AA, the 6 pm-6 am nurse, at 6:00 pm. The 6 pm dose was administered two hours after the 4:00 pm dose was administered. Record review of Progress Notes dated 3/6/2024 at 9:28 am for R1 revealed resident noted with decreased responsiveness. VS (vital signs) 118/60, 89, 97.1, 24, 92% on O2 (oxygen) @ 2LPM (liters per minute) via NC (nasal cannula). Pupils constricted with decreased responsiveness. The resident received multiple doses of oxycodone 5mg for the pain in the left hip. MD (Medical Director) notified. New order to administer Narcan 4mg nasal spray, after 5 minutes if not effective administer 2nd dose and send to ER (emergency room) for evaluation. 1st dose administered at 9:30 am, resident aroused for a few minutes but was still noted to be drowsy. 2nd dose administered at 9:37 am, and EMS (Emergency Medical System) called. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	2. Record review of the EMR revealed R2 was admitted to the facility on [DATE] with diagnosis of fracture of unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing. Record review revealed R2 had a physician order with a start date of 3/4/2024 for oxycodone HCL 10 mg to be administered by mouth every six hours as needed for pain. A review of R2's Controlled Substance Proof of Use Form revealed the following documentation: oxycodone HCL 10 mg was signed out and administered on 3/5/2024 at 3:00 pm by the 6 am-6 pm nurse. And then signed out by LPN AA, the 6 pm-6 am nurse, at 6:00 pm. The 6 pm dose was administered three hours after the 3:00 pm dose was administered. Record review of Progress Notes dated 3/6/2024 at 9:29 am revealed R2 observed to have decreased responsiveness and increased drowsiness. VS 123/48, 99.0, 85, 92% RA, 14. Tremors noted to bilateral upper extremities. The resident received multiple doses of oxycodone 10 mg for generalized body pain. MD notified and new order to administer Narcan Nasal Spray 4 mg. If non-effective after 5 minutes, administer second dose. Send to ER if ineffective. Administered first dose of Narcan at 9:29 am in left nostril. Resident observed with increased responsiveness. Able to tell nurse what her name is and where she is located. Remains with increased drowsiness but is able to answer questions when asked. MD notified and states to monitor resident for decrease in responsiveness. VS 104/53, 96% RA, 85, 98.7. Record review of Progress Notes dated 3/6/2024 at 10:55 am for R2 revealed Certified Nursing Assistant (CNA) reported the resident rolled out of bed. Upon entering the room, Resident was observed laying on the floor on her L side, back up against the ptac [sic] unit. CNA reported the resident attempted three times to get up and she was able to prevent but this time she was unable to get to her before she rolled off the bed. Resident is currently on a low air loss mattress due to wounds. Head to toe assessment completed, new area to the R lower calf, blister previously documented open with top layer of skin gone. Redness noted to [sic] the back of the neck. MD notified, new order to send to ER for evaluation. Staff assisted Resident up to sitting position and with EMS help lifted her onto stretcher. Resident sent to ER for evaluation. Director of Nursing (DON) notified. Record review of Progress Notes dated 3/6/2024 at 10:55 am R2 returned to the facility from the hospital via EMS. Hospital paperwork sent back with patient with discharge diagnoses sepsis and rhabdomyolysis. ER MD noted that she needed to be hospitalized but resident declined hospitalization at this time. Interview on 3/12/2024 at 8:30 am with the DON revealed an incident with Licensed Practical Nurse (LPN) AA administering pain medications for two residents (R1 and R2) without reviewing the Medication Administration Record (MAR) before giving medication to see if the residents were previously medicated. As a result, one of the residents was sent immediately to the hospital. Further interview also revealed that LPN AA had worked the night shift at the facility full time since November or December of 2023. During this time, two other disciplinary actions were conducted for LPN AA, which included not completing wound care for assigned residents and administering (PRN) pain medication to residents routinely without a pain assessment. It was also determined that the DON did report to the State Agency and reported LPN AA to the Nursing Board, and confirmation verified. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Interview on 4/8/2024 at 12:57 pm with DON revealed LPN AA was not a new nurse but new to the facility. She stated that LPN AA stated that if residents had prn pain medications or complained of pain, she just gave them pain medications. She stated LPN AA works 6 pm-6 am shift. The DON revealed LPN AA clocked in at 6:15 pm and signed the narcotic sheet for 6 pm on 3/5/2024. The DON stated that she was not doing a documented narcotic audit. The DON revealed since the March 5, 2024 incident; she has been doing daily narcotic audits of the PRN meds with no discrepancies. DON also stated that R2's Narcan was effective, and later that morning, she had a fall, was sent to the ER, and returned. She stated that R1 was still drowsy after she received Narcan, and she was sent to the hospital for evaluation. She did not return to the facility per family choice after admission to the hospital. The DON further revealed that the nursing staff had been educated on medication administration.