STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. 21213 Based on staff interviews and record review, the facility failed to ensure that medications were administered as care planned to ensure critical laboratory results remained within a therapeutic range for one of nine residents (R) (R1) sampled. On 4/16/2024 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Director of Nursing, and nurse consultant via phone were informed of the Immediate Jeopardy (IJ) on 4/16/2024 at 10:15 am. The noncompliance related to the IJ was identified to have existed on 12/30/2023. An Acceptable IJ Removal Plan was received on 4/17/2024. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 4/17/2024. Findings include: Review of R1's care plan revealed a care plan problem, dated 1/9/2024, for critical lab values. The care plan problem included an intervention for nursing staff to administer medications as ordered and labs as ordered. The goal of the care plan problem was that R1 would not require hospitalization related to critical lab values during the review period. A review of R1's clinical record revealed diagnoses that included but were not limited to, liver transplant status and gangrene of gallbladder in cholecystitis. A review of the physician's orders revealed that R1's medications on admission to the facility included the anti-rejection medication cyclosporine. The cyclosporine order included two 100 milligrams (mg) capsules to be administered two times per day for liver transplant status. A review of the December 2023 eMAR revealed that the medication was scheduled to be administered at 9:00 am and 9:00 pm. A review of the pharmacy's daily audit logs revealed that thirty 100 mg cyclosporine capsules were filled by the pharmacy for R1 on 12/22/2023. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R1's December 2023 eMAR revealed that the medication was documented as being started on 12/22/2023 at 9:00 pm. Based on the physician's order of two 100 mg capsules being administered two times daily, the thirty 100 mg capsules would have lasted through the 12/29/2023 9:00 pm dose. However, a review of the December 2023 and January 2024 eMARs revealed that both doses of the cyclosporine medication on 12/30/2023 and the 9:00 am dose on 12/31/2023 are documented as administered to R1. The 9:00 pm dose on 12/31/2023, both doses on 1/1/2024, and the 9:00 am dose on 1/2/2024 are not documented as being administered. Although the cyclosporine medication ran out on 12/29/2023, there was no evidence that facility nursing staff followed up with the pharmacy or that the cyclosporine medication was refilled until 1/2/2024. A review of R1's nurses' notes revealed a 1/19/2024 entry that the on-call pharmacist was notified of the change in the dosage of the cyclosporine and that the pharmacy had to order the medication. Further review of the nurses' notes revealed entries on 1/20/2024 and 1/21/2024 that documented nursing staff following up with the pharmacy concerning the status of the medication. The 1/20/2024 nurse's note entry documented that the pharmacist said the medication would be sent out on the night of 1/22/2024. The 1/21/2024 nurse's note entry documented that the pharmacist had contacted three local backup pharmacies, and none of them had the ordered dose of the cyclosporine medication. A review of the pharmacy daily audit logs and the January 2024 eMAR revealed that sixty 25 mg cyclosporine capsules were dispensed on 1/22/2024, and the medication was administered to R1 starting on 1/22/2024 at 9:00 pm. The order for three 25 mg capsules of cyclosporine two times per day continued until 2/8/2024. On 2/8/2024, the order was increased to cyclosporine 125 mg (one 100 mg capsule and one 25 mg capsule) two times per day. Further review of the pharmacy daily audit logs and the January 2024 and February 2024 eMAR revealed that thirty 25 mg cyclosporine capsules and thirty 100mg capsules were dispensed on 2/8/2024 and administered to R1 starting on 2/8/2024 at 9:00 pm. The order of cyclosporine 125 mg twice daily continued until R1 was discharged from the facility on 2/14/2024. Interview on 3/20/2024 at 10:13 am, Senior Manager HH confirmed that cyclosporine is the main immunosuppressant medication. When questioned if there were any other reasons the cyclosporine level would be undetectable other than the medication not being administered, Senior Manager HH responded no. She stated that the medication would either be an insufficient dose or not administered at all. Senior Manager HH stated that R1's initial cyclosporine goal on discharge from the hospital (12/21/2023) was 150-180, and the goal was to keep him within this range. She further revealed having difficulty getting lab work from the facility due to it being a send-out laboratory test for the facility. This would cause a delay in medication adjustments because of waiting for test results. The facility implemented the following actions to remove the IJ: 1.R1 was discharged from the facility on 2/14/2024 and no other residents in the facility are receiving antirejection medication. 2. On 4/16/2024, the policy for comprehensive care plans titled Patient's Plan of Care was reviewed by the Administrator, DON, and Divisional Nurse with no revisions made. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. On 4/16/2024, The DON, Assistant Director of Nursing (ADON) and nurse managers reviewed all 58 of 58 resident's medication records and medication carts audited to ensure that medication was available for administration as indicated in the plan of care beginning at 2:20 pm and completed at 4:00 pm. 4. On 3/11/2024 at 3:45 pm, The Divisional Nurse in- serviced 5 of 5 nurse managers including the DON, ADON, Registered Nurse (RN) Nurse Manager, Resident Assessment Instrument (RAI) Director, and Wound Care Coordinator regarding medication administration that includes inquiry of unavailable medication with the pharmacy, obtaining from back up pharmacy, notifying the provider of unavailable medication and obtaining orders to hold until available or change and/ or discontinue medication as outlined in the facility's policy titled Medication Unavailable for Administration to ensure the plan of care is being followed. 5. On 3/14/2024, The DON initiated education for licensed nurses and Certified Medication Aides (CMAs) regarding following the plan of care regarding medication administration that includes inquiry of unavailable medication with the pharmacy, obtaining from back up pharmacy, notifying the provider of unavailable medication and obtaining orders to hold until available or change and/ or discontinue medication as outlined in the facility's policy titled Medication Unavailable for Administration. 6. On 3/15/2024, The Divisional Nurse implemented a monitoring tool, F656 Development/Implementation of Comprehensive POC Audit Tool regarding administration of medication to include medication not administered due to unavailability and completed by the DON or nurse managers five times per week, Monday through Friday, to include review of medication administered on weekends. 7. As of 4/16/2024, _11_ of _12_ nurses (_6_ RNs, _6_ LPNs for a total of 92%) and _6_ of _6_ CMAs (for a total of 100%) were educated on documentation and following the plan of care for medication administration. 8. The remaining _1_ LPN nurse will be in- serviced on the next scheduled workday prior to beginning their shift by the Director of Nursing. Any RNs, LPNs and CMAs that are PRN or on LOA will be provided education upon return to work. Newly hired RNs, LPNs, and CMAs will be provided education during the orientation process. 9. The Administrator reviewed the results of the audit on 4/16/2024 during an ADHOC QAPI meeting. 10. All Corrective Actions were completed on April 16, 2024. 11. The facility alleges that the IJ is removed on April 17, 2024. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. R1's discharge date was verified via review of the closed clinical record, including the 2/14/2024 Minimum Data Set (MDS) Discharge assessment. During an interview on 4/18/2024 at 2:50 pm, the DON confirmed there were no residents currently receiving antirejection medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Verified via review of a copy of the Patients Plan of Care policy signed as being reviewed on 4/16/2024 with no changes made. The signatures of the Administrator, DON and Divisional Nurse were included. During an interview on 4/18/2024 at 2:50 pm, the Administrator, DON, and Divisional Nurse confirmed they reviewed the policy on 4/16/2024 with no revisions. 3. Verified via review of the Quality Improvement Data Collection Grids labeled Medication ordered for administration was available and dated 4/16/2024. The audits included halls 100, 200, 300 and 400 and all indicated that ordered medications were available for administration. The 100 and 300 hall audit forms were signed as completed by DON. The 200-hall form was signed as completed by the DON and Education Nurse. The 400-hall form was signed as completed by the Education Nurse. During an interview on 4/18/2024 at 10:13 am, the Education Nurse confirmed she assisted the DON in completing the medication cart audits and all medications were available for administration. During an interview on 4/18/2024 at 2:50 pm, the DON confirmed completing the medication records and medication cart audits. Observations of medication administration for R12, R13, R14, R15, R16 and R17 were conducted on 4/18/2024 with LPN LL, RN MM, CMA AA, and CMA KK. Medications were observed to be available and were administered as care planned and ordered, with no significant medication errors. 4. Verified via review of a copy of the Medication Unavailable for Administration policy which included education was provided by the Divisional Nurse on 3/11/2024. The signatures of the DON, Education Nurse, Wound Care Coordinator, RAI Coordinator, and ADON were included. Staff interviews conducted on 4/18/2024 at 10:13 am with the Education Nurse, at 10:47 am with the Resident Assessment Instrument (RAI) Director, at 11:10 am with the Wound Care Coordinator, at 12:25 pm with the ADON, at 2:50 pm with the Divisional Nurse, and DON who confirmed that the Divisional Nurse had in-serviced them on the policy. During the interview on 4/18/2024 at 10:47 am, the RAI Director stated that a care plan of administering medications as ordered was usually for a specific diagnosis or problem or acute situation that would include administering medications as ordered (to address the condition). 5. Verified via review of clinical meeting documentation, dated 3/14/2024, a copy of the new Medication Aide to Nurse Communication form, and staff signature sheets. The staff signature sheets included six CMAs, six LPNs and five RNs, for a total of 17 nursing staff educated. During an interview on 4/18/2024 at 12:50 pm, the Divisional Nurse clarified that the education was provided from 3/12/2024 through 3/14/2024. During an interview on 4/18/2024 at 2:50 pm, DON also confirmed that she initiated education on 3/12/2024 and it continued through 3/14/2024. During an interview on 4/18/2024 at 12:25 pm, ADON confirmed that the new process had been implemented. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Verified via review of the Quality Improvement Data Collection Grid audit tools that were labeled as: 1) Were there medications not administered? 2) Was the MD notified? 3) If applicable, was order placed to hold medication? The audit tools were dated as completed 3/18/2024 through 4/17/2024. The tools included additional comments and follow-up information for any medications that were not administered. During an interview on 4/18/2024 at 12:25 pm, ADON stated that she had assisted DON in completing the audits, and so far, they had gone well. During an interview on 4/18/2024 at 2:50 pm, the Divisional Nurse confirmed implementation of the audit tool and the DON confirmed completing the audits with the assistance of the ADON. 7. Verified via review of clinical meeting documentation, dated 3/14/2024, a copy of the new Medication Aide to Nurse Communication form, and staff signature sheets. The staff signature sheets included six CMAs, six LPNs and five RNs, for a total of 17 nursing staff educated. During an interview on 4/18/2024 at 10:40 am, the Divisional Nurse stated that the total of 12 nurses included in this education were all full-time nurses. She confirmed that there were three additional nurses; one on leave of absence (LOA), with no return date specified, and two that worked prn (as needed). She confirmed that education would be completed by the DON with the additional nurses when they returned to work. During an interview on 4/18/2024 at 12:50 pm, the Divisional Nurse clarified that the education was provided from 3/12/2024 through 3/14/2024. During an interview on 4/18/2024 at 2:50 pm, DON also confirmed that she initiated education on 3/12/2024 and it continued through 3/14/2024. During an interview on 4/18/2024 at 12:25 pm, ADON confirmed that the new process had been implemented. Staff interviews conducted on 4/18/2024 at 10:13 am with the Education/Infection Control RN JJ, at 10:27 am with CMA/Certified Nursing Assistant (CMA/CNA) KK, at 10:47 am with the RAI Director, at 11:00 am with LPN LL, at 11:10 am with the Wound Care Coordinator, at 11:25 am with RN Charge Nurse MM, at 11:37 am with CMA NN, at 12:00 pm with CMA AA, at 12:05 pm with CMA QQ, at 12:29 pm with LPN OO, at 2:13 pm with RN TT, at 2:21 pm with RN RR, and at 3:18 pm with LPN SS, confirmed they had received education regarding following the plan of care regarding medication administration that included inquiry of unavailable medication with the pharmacy, obtaining from back up pharmacy, notifying the provider of unavailable medication and obtaining orders to hold until available or change and/or discontinue medication as outlined in the facility's policy titled Medication Unavailable for Administration. They also confirmed they received education on documentation and following the plan of care for medication administration. 8. During an interview on 4/18/2024 at 10:40 am, the Divisional Nurse stated that the last full-time nurse (LPN PP) was educated on the evening of 4/17/2024. A review of the in-service signature sheet, labeled Hold medication order Education revealed that LPN PP had been educated on 4/17/2024. During the interview with the Divisional Nurse on 4/18/2024 at 10:40 am, she stated that there was one nurse on LOA (with no return date specified) and two nurses that worked on an as needed basis. She confirmed that education would be completed by the DON with the additional nurses when they returned to work. During an interview on 4/18/2024 at 2:21 pm, RN RR confirmed that she worked at the facility on an as needed basis and had received the in-service education from the DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/18/2024 at 2:50 pm the DON confirmed that education would be provided to newly hired RNs, LPNs, and CMAs during the orientation process by the nurse manager assigned to them at that time. 9. Verified via review of ADHOC QAPI meeting documentation, dated 4/16/2024, that included signatures of the Administrator, DON, Divisional Nurse, and Medical Director. Also verified via review of the Quality Improvement Data Collection Grid, dated 4/16/2024, and labeled as Audits of abatement were reviewed. The form included the Administrator's signature. 10. All Corrective Actions were completed on April 16, 2024. 11. The facility alleges that the IJ is removed on April 17, 2024.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 21213 Based on observations, staff interviews, record review, and review of the facility policy titled, Medication Administration-General, the facility failed to ensure the medication error rate was less than 5%. A total of 35 opportunities were observed with four errors for three residents (R) (R2, R7, and R8) resulting in an error rate of 11.4%. This failure had the potential to result in medication not being given in accordance with the physician's orders and had the potential to adversely affect R2, R7 and R8's clinical condition. Findings include: Review of the facility policy titled, Medication Administration-General, dated 2024. The policy guidelines included that medications are administered in accordance with a valid prescriber order. The guidelines also instructed the Nurse or Certified Medication Aide (CMA), prior to medication administration, to read the administration directions on the Medication Administration Record (MAR) and verify the correct medication, dose, and directions for use. Review of the clinical record revealed that R2 had a physician's order, dated 10/12/2023, for 2 grams of diclofenac 1% topical gel to be applied to her bilateral knees and hands two times per day for joint pain. Review of the electronic Medication Administration Record (eMAR) revealed that the medication was scheduled to be administered at 10:00 am and 10:00 pm. However, during an observation on 3/13/2024 at 9:35 am, Certified Medication Assistant (CMA) AA failed to administer the diclofenac topical gel as scheduled. At the time of the observation, CMA AA stated that the gel was not on the medication cart. During an interview on 3/13/2024 at 9:50 am, the Director of Nursing (DON) stated that the medication had been ordered electronically on 3/10/2024, but that the order did not go through for some reason. The pharmacy had been contacted and would send the medication that night. 2. Review of the clinical record revealed that R7 had a physician's order, dated 2/9/2022, for Artificial Tears 83%-15% eye ointment to be applied to both eyes two times per day for dry eye syndrome. Review of the eMAR revealed that the medication was scheduled to be administered at 9:00 am and 9:00 pm. However, during an observation on 3/13/2024 at 9:29 am, CMA AA failed to administer the Artificial Tears eye ointment as ordered. CMA AA administered Artificial Tears eye drops (two drops in each eye) in error. During an interview on 3/14/2024 at 8:50 am, the DON stated that Artificial Tears was a stock medication, and they only had the eye drops (not the ointment). A Further review of R7's clinical record revealed a physician's order, dated 11/4/2023, for 30 milliliters (ml) of lactulose 10grams/15ml to be mixed with 4 to 8 ounces of water and administered daily. Review of the eMAR revealed the medication was scheduled to be administered at 9:00 am. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, during an observation on 3/13/2024 at 9:30 am, CMA AA failed to administer the lactulose medication as ordered. At the time of the observation, CMA AA stated that the lactulose was not available on the medication cart. 3. Review of the clinical record revealed that R8 had a physician's order, dated 9/29/2022, for two 1000 milligram (mg) tablets of cyanocobalamin (vitamin B-12) to be administered daily for age-related osteoporosis. Review of the eMAR revealed that the medication was scheduled to be administered at 10:00 am. However, during an observation on 3/19/2024 at 9:25 am, Licensed Practical Nurse (LPN) BB only administered one 1000 mg cyanocobalamin tablet, instead of two, as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. 21213 Based on staff interviews, record reviews, and a review of the facility policy titled, Obtaining and Receiving Medications from Pharmacy, the facility failed to ensure that one of nine sampled residents (R) (R1) obtained medications timely, administered as ordered, and medication trough levels were maintained within a therapeutic range for R1. On 4/16/2024 a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. The facility's Administrator, Director of Nursing, and nurse consultant via phone were informed of the Immediate Jeopardy (IJ) on 4/16/2024 at 10:15 am. The noncompliance related to the IJ was identified to have existed on 12/30/2023. An Acceptable IJ Removal Plan was received on 4/17/2024. Based on observation, record reviews, review of facility policies as outlined in the Removal Plan, and staff interviews, it was validated that the corrective plans and the immediacy of the deficient practice was removed on 4/17/2024. Findings include: The facility policy titled Obtaining and Receiving Medications from Pharmacy, dated 2019 revealed the policy's Procedure section included that medication orders are faxed and/or electronically transmitted to the pharmacy. Once, received by the pharmacy, the pharmacy will dispense the medication after review. The nurse communicates to the pharmacy the required elements of an order. Review of R1's clinical record revealed that he resided at the facility from 12/21/2023 through 2/14/2024 and had diagnoses that included, but were not limited to, liver transplant status and gangrene of gallbladder in cholecystitis. Review of physician's orders revealed that R1's medications on admission to the facility included an anti-rejection medication, cyclosporine. The cyclosporine order included two 100 milligrams (mg) capsules to be administered two times per day for liver transplant status. A review of the December 2023 electronic Medical Record (eMAR) revealed that the medication was scheduled to be administered at 9:00 am and 9:00 pm. Review of the pharmacy daily audit logs revealed that thirty 100 mg cyclosporine capsules were filled by the pharmacy for R1 on 12/22/2023. Review of R1's December 2023 eMAR revealed that the medication was documented as being started on 12/22/2023 at 9:00 pm. Review of the December 2023 and January 2024 eMARs revealed that the 9:00 pm dose on 12/31/2023, the 9:00 am and 9:00 pm doses on 1/1/2024, and the 9:00 am dose on 1/2/2024 were not documented as being administered. Although there was no evidence that facility nursing staff followed up with the pharmacy or that the cyclosporine medication was refilled until 1/2/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the pharmacy audit logs and R1's January 2024 eMARs revealed that thirty, 100 mg capsules of cyclosporine was refilled on 1/2/2024, and the medication was administered on 1/2/2024 at 9:00 pm. Further review of the pharmacy audit logs revealed that the cyclosporine medication was again refilled on 1/10/2024 with 30 capsules dispensed. Based on the physician's order of two 100 mg cyclosporine capsules being administered two times daily, the amount of medication dispensed would have lasted through the 9:00 am dose on 1/17/2024. However, further review of the January 2024 eMAR revealed that the 9:00 pm dose on 1/17/2024, both doses on 1/18/2024, and the 9:00 am dose on 1/19/2024 are documented as administered to R1. Review of the physician's order for R1 on 1/19/2024 revealed a cyclosporine order included for nursing staff to administer three 25 mg capsules twice daily. Review of the pharmacy daily audit logs and the January 2024 eMAR revealed that sixty 25 mg cyclosporine capsules were dispensed on 1/22/2024, and the medication was administered to R1 starting on 1/22/2024 at 9:00 pm. The order for three 25 mg capsules of cyclosporine two times per day continued until 2/8/2024. Review of the physician's order on 2/8/2024 revealed the order was increased to cyclosporine 125 mg (one 100 mg capsule and one 25 mg capsule) two times per day. Further review of the pharmacy daily audit logs and the January 2024 and February 2024 eMARs revealed that thirty 25 mg cyclosporine capsules and thirty 100mg capsules were dispensed on 2/8/2024 and administered to R1 starting on 2/8/2024 at 9:00 pm. The order of cyclosporine 125 mg twice daily continued until R1 was discharged from the facility on 2/14/2024. Review of hospital discharge documentation from R1's 12/21/2023 hospital discharge revealed that R1's cyclosporine goal range was 150-180 (measurement not specified). The purpose of the medication was noted to prevent rejection, and the medication should be taken after blood is drawn on lab days. A review of the physician's orders revealed a 12/26/2023 order for a cyclosporine level to be obtained every Monday and Thursday. Further review of the clinical record and laboratory test results revealed that cyclosporine trough levels were collected on 12/28/2023 at 2:28 am, 1/5/2024 at 4:05 pm, 1/9/2024 at 2:58 am, 1/18/2024 at 2:12 am, 1/20/2024 at 11:30 am, 1/22/2024 at 3:03 am, 1/25/2024 at 12:00 am, 1/29/2024 at 12 am and 9:30 am, 2/1/2024 at 8:15 am, 2/5/2024 at 12:00 am, 2/9/2024 at 9:00 am, 2/12/2024 at 12:00 am, and on 2/13/2024 at 8:50 am. All the cyclosporine laboratory samples that were obtained in December 2023, January 2024, and on 2/5/2024 and 2/12/2024 were obtained by the facility and sent to a local laboratory or were obtained by and sent to an outside laboratory service the facility utilized for obtaining routine laboratory tests. A review of the cyclosporine trough level laboratory results from the local laboratory and the outside laboratory service revealed that the type of test was an immunoassay, and the reference range was from 100-200 micrograms per liter (mcg/L) for kidney transplantation and 200-300 mcg/L for other organ transplants. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The cyclosporine laboratory samples that were obtained on 2/1/2024, 2/9/2024, and 2/13/2024 were obtained using laboratory sample kits that were provided by R1's hospital transplant team that shipped to the facility, then were shipped back to the hospital laboratory, where R1 had his liver transplant performed. Review of the cyclosporine trough level laboratory results from the transplant hospital laboratory revealed the type of test was done by Liquid Chromatography Tandem Mass Spectrometry. The reference range was from 10-230 nanograms per milliliter (ng/ml). Review of R1's nurse's notes revealed a 1/29/2024 entry by the Assistant Director of Nursing (ADON) that documented contact with R1's hospital service, who inquired about the cyclosporine trough and times that it was drawn. The nurse stated that the trough could not be drawn by the lab at 3:00 am in the morning due to that being too close to the time that R1 received his every 12-hour cyclosporine dose. The note further documented that the trough needed to be drawn closer to 12 hours after R1 received a dose and before the next dose was given. The ADON documented that she informed the hospital service that she would start drawing the laboratory samples before R1 was given the morning dose of cyclosporine on Mondays and Thursdays. The samples would be taken to the local laboratory. The note documented that the hospital service agreed with the process until the facility received the laboratory kits; upon receipt of the laboratory kits, samples would then be sent back to the transplant hospital laboratory. Further review of the cyclosporine laboratory test results revealed that none of the cyclosporine laboratory results were within the goal range of 150-180 set at R1's 12/21/2023 hospital discharge and the facility admitted . For the cyclosporine trough levels obtained from the local hospital and outside laboratory service, only the 1/18/2024 cyclosporine trough (with a report date of 1/22/2024) of 271 mcg/L fell within the suggested range of 200-300 mcg/L for other organ transplants. Following an elevated 1/9/2024 cyclosporine trough level (with a report date of 1/14/2024) of 446 mcg/L, the cyclosporine order of two 100 mg capsules twice daily was decreased to three 25 mg capsules twice daily. Following the 2/1/2024 cyclosporine trough level (with a result date of 2/3/2024) of 47 ng/ml, the cyclosporine order was increased to 125 mg twice daily. However, despite the increase in the cyclosporine dose on 2/8/2024, the cyclosporine trough levels continued to decline. The 2/9/2024 trough level (with a result date of 2/12/2024) was 44 ng/ml. The 2/13/2024 trough level (with a result date of 2/15/2024, which was after discharge from the facility) was less than 20 (<20). R1 was discharged from the facility on 2/14/2024. A review of the Notice of Transfer or Discharge form, dated 2/14/2024, documented that R1 was finished with therapy and was going home. However, after R1 was discharged from the facility on 2/14/2024, he was directly admitted to the hospital (where he previously had a liver transplant) on 2/16/2024. A review of hospital documentation revealed a 2/17/2024 attestation statement by physician II that R1 was admitted in the setting of acutely elevated graft indices and jaundice in the setting of low cyclosporine levels with poor administration at the facility. The physician's notes documented suspected acute cellular rejection and that R1 was a direct admittance from the transplant clinic related to elevated Liver Function Tests (LFTs). Additional hospital physician documentation from 2/18/2024 included that R1 was possibly not (sic) getting medications in the facility on a timely basis. The cyclosporine level on 2/13/2024 was undetectable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of R1's physician's orders revealed that his medications also included another anti-rejection medication, mycophenolate mofetil. The mycophenolate mofetil order included one 500 mg mycophenolate to be administered two times per day for liver transplant status. The medication was ordered from 12/21/2023 through 2/14/2024. A review of the eMAR's revealed that the medication was scheduled to be administered at 9:00 am and 9:00 pm. Review of the pharmacy daily audit logs revealed that the pharmacy dispensed thirty 500 mg tablets of mycophenolate mofetil on 12/21/2023, 30 tablets on 1/20/2024, 13 tablets on 1/23/2024, 13 tablets on 2/3/2024, and 13 tablets on 2/8/2024 for a total of 99 tablets. Review of the Discharge Instructions for Care form, dated 2/14/2024, revealed that six of the mycophenolate mofetil tablets were sent home with R1 on discharge. Therefore, 93 of the 99 tablets dispensed from the pharmacy would have been available for administration during R1's stay at the facility. A review of the December 2023 eMAR's revealed that the medication was started on 12/21/2023 at 9:00 pm. Review of the clinical record revealed a 12/29/2023 nurse's note entry that documented a new order from R1's transplant team physician to place the mycophenolate mofetil on hold for five days. A review of the December 2023 eMAR's revealed that the medication was held as ordered from the 9:00 pm dose on 12/29/2023 through the 9:00 am dose on 1/3/2024. Further review of the December 2023, January 2024, and February 2024 eMAR's revealed that all other doses were documented as administered starting on 12/21/2023 at 9:00 pm through 2/14/2024 at 9:00 am. However, the number of doses of mycophenolate mofetil documented as administered totaled 100 tablets, which is seven more tablets than the 93 that would have been available to administer. Review of physician's orders for R1 dated 12/21/2023 through 1/16/2024 revealed an order for an antiviral medication, valganciclovir. Additional review of physician's orders revealed a 12/21/2023 order for two 450 mg tablets of valganciclovir to be administered two times per day for gangrene of the gallbladder in cholecystitis. A review of the December 2023 eMAR revealed that the medication was scheduled to be administered at 9:00 am and 9:00 pm. Review of the pharmacy daily audit logs revealed that the pharmacy dispensed fifteen 450 mg tablets of valganciclovir on 12/22/2023, 12 tablets on 12/30/2023, 12 tablets on 1/2/2024, 12 tablets on 1/6/2024, 12 tablets on 1/10/2024 and 12 tablets on 1/14/2024 for a total of 75 tablets (37.5 doses). A review of the December 2023 eMAR revealed that the medication was first administered on 12/22/2024 at 9:00 pm. Further review of the December 2023 eMAR and review of the January 2024 eMAR revealed that nursing staff documented administering a total of 47 doses (94 tablets) of valganciclovir, which is 8.5 (19 tablets) more than what was provided by the pharmacy. During an interview on 3/13/2024 at 11:45 am with the Licensed Practical Nurse (LPN) BB stated that routine medications that come in the packs are automatically refilled and delivered on Saturdays. For other medications, you just must keep an eye on when they are running low, and for narcotics, she usually reorders when a resident gets down to about 10 pills. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/18/2024 at 10:50 am with the Regional Nurse Consultant DD stated that the cyclosporine capsules were sent from the pharmacy in the manufacturer's packaging. During an interview on 3/18/2024 at 1:26 pm with a family member of R1 confirmed that R1 remained hospitalized . During an interview on 3/19/2024 at 2:25 pm with the Director of the hospital laboratory service explained that a cyclosporine trough level of <20 would be treated as a negative, and that there was no drug detectable in that sample. She stated that the lab test that was used (mass spectrometry) was highly accurate. During an interview on 3/20/2024 at 10:13 am with the Senior Manager HH of the hospital transplant clinic confirmed that R1 was admitted to the hospital for post-transplant rejection on 2/16/2024. She stated that he had stabilized and that his immunosuppressant had been changed. When asked if an undetectable cyclosporine level alone could cause liver transplant rejection, even if the patient were receiving other medications, she stated that it absolutely could. Senior Manager HH stated that the body's natural response is to attack (the donor's liver), and without the immunosuppressant to quell the response, the body will attack it. The immunosuppressant becomes the lifeline. Cyclosporine is the main immunosuppressant medication. When questioned if there were any other reasons the cyclosporine level would be undetectable other than the medication not being administered, Senior Manager HH responded no. She stated that the medication would either not be a sufficient dose or not be administered at all. Senior Manager HH stated that R1's initial cyclosporine goal on discharge from the hospital (12/21/2023) was 150-180 ng/ml. When questioned if the cyclosporine doses ordered by the physician (while at the facility) were sufficient to keep R1 within that goal range, she stated yes, the intent was to keep him within that range. Senior Manager HH stated that they had trouble getting lab work from the facility; there was a delay in getting cyclosporine trough levels because it was a send out laboratory test for the facility. It would be several days before they would get the results, and then they (the hospital service) would make medication adjustments. During an interview on 3/20/2024 at 2:15 pm, the Regional Nurse Consultant DD stated that the nurses could refill medication electronically from the eMAR. They can also pull the stickers (off the package) and fax them to the pharmacy. The traditional medications refill automatically. Regional Nurse Consultant DD stated that some examples of medications that would not be automatically refilled would be medications with limited duration, such as an antibiotic or a medication that is lab based and may change often. During an interview on 3/21/2024 at 12:35 pm with the ADON confirmed that she obtained R1's laboratory samples for the laboratory kits sent from the hospital transplant team. She stated that the samples were sent back overnight to the transplant hospital laboratory. The ADON stated that they (facility staff) discussed in the morning meeting that the cyclosporine trough samples needed to be drawn 12 hours after taking the medication and before the next dose was given, and they did not know that. The ADON stated that when she started obtaining R1's laboratory samples when she got to the facility in the morning, she would let the nurse or Certified Medication Aide (CMA) know not to give the cyclosporine medication before she drew the laboratory sample that morning. The facility implemented the following actions to remove the IJ: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. R1 was discharged from the facility on 2/14/2024, there are no other residents in the facility receiving antirejection medication. 2. On 4/16/2024, the policy for Medication Unavailable for Administration was reviewed by the Division Nurse, DON, and Administrator with no changed in policy noted. 3. A root cause analysis was identified for medication being unavailable and a Performance Improvement Plan (PIP) was developed on 3/13/2024 regarding CMAs lack of awareness of the reordering process and reporting missing medication to the nurse. The PIP was updated on 3/15/2024 as an allegation of compliance and incorporated into the facility's Quality Assurance Performance Improvement (QAPI) process. An ADHOC QAPI meeting was conducted with the medical director on 3/22/2024. 4. On 3/14/2024, education was provided by the DON to Licensed Nurses (Registered Nurse (RN) and Licensed Practical Nurse (LPN)) and Certified Medication Aides (CMAs) regarding reordering of medication as outlined in the Medication Unavailable for Administration policy, including best practices for reordering medication when 5-7 days of medication are remaining as well as regarding medication administration that includes inquiry of unavailable medication with the pharmacy, obtaining from back up pharmacy, notifying the provider of unavailable medication and obtaining orders to hold until available or change and/ or discontinue medication. 5. On 3/15/2024, The Divisional Nurse implemented a monitoring tool, F760 Significant Medication Error regarding administration of medication to include medication not administered due to unavailability and completed by the DON or nurse managers five times per week, Monday through Friday, to include review of medication administered on weekends. 6. As of 4/16/2024, _11_ of _12_ nurses (_6_ RNs and _6_ LPNs for a total of 93%) and _6_ of _6_ CMAs (for a total of 100%) were educated on documentation and follow up with pharmacy and MD regarding medications not available and best practices for ordering of medication process. 7. The remaining _1_ LPN nurse will be in- serviced on the next scheduled workday prior to beginning their shift by the Director of Nursing regarding medication administration that includes inquiry of unavailable medication with the pharmacy, obtaining from back up pharmacy, notifying the provider of unavailable medication and obtaining orders to hold until available or change and/ or discontinue medication. Any RNs, LPNs and CMAs that are PRN or on LOA will be provided education upon return to work. Newly hired RNs, LPNs, and CMAs will be provided education during the orientation process. 8. The Administrator reviewed the results of the audit on 4/16/2024 during an ADHOC QAPI meeting. 9. All Corrective Actions were completed on April 16, 2024. 10. The facility alleges that the IJ is removed on April 17, 2024. The State Survey Agency (SSA) validated the facility's written IJ Removal Plan as follows: 1. R1's discharge date was verified via review of the closed clinical record, including the 2/14/2024 Minimum Data Set (MDS) Discharge assessment. During an interview on 4/18/2024 at 2:50 pm, the DON confirmed there were no residents currently receiving antirejection medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Verified via review of a copy of the Medication Unavailable for Administration policy that was signed as being reviewed on 4/16/2024. The signatures of the Administrator, DON, and Divisional Nurse were included. During an interview on 4/18/2024 at 2:50 pm, the Administrator, DON and Divisional Nurse confirmed they reviewed the policy on 4/16/2024 with no revisions. 3. Verified via review of the Performance Improvement Project (PIP) form, dated 3/13/2024. The problem described on the PIP is nurses not notifying the provider when medication is not available. The root cause analysis was listed as CMAs lack of understanding of the reordering process and not always reporting missing medication to the nurse. Also verified via review of the Allegation of Compliance plan with a beginning date of 3/15/2024, that documented a corrective action plan for residents receiving medication in correct dosage and administration time. Also verified via review of the 3/22/2024 QAPI meeting minutes and staff signature sheet, which included the Medical Director. During an interview on 4/18/2024 at 12:50 pm, the Divisional Nurse confirmed development of the PIP on 3/13/2024 and then updated it to an Allegation of Compliance on 3/15/2024. During an interview on 4/18/2024 at 2:50 pm, the Administrator, DON and Divisional Nurse confirmed the QAPI meeting held on 3/22/2024. 4. Verified via review of clinical meeting documentation, dated 3/14/2024, a copy of the new Medication Aide to Nurse Communication form, and staff signature sheets. The staff signature sheets included six CMAs, six LPNs, and five RNs, for a total of 17 nursing staff educated. During an interview on 4/18/2024 at 12:50 pm, the Divisional Nurse clarified that the education was provided from 3/12/2024 through 3/14/2024. During an interview on 4/18/2024 at 2:50 pm, DON also confirmed that she initiated education on 3/12/2024 and it continued through 3/14/2024. The DON stated that communication between the CMAs and nurses had improved. During an interview on 4/18/2024 at 12:25 pm, ADON confirmed that the new process had been implemented. Observations of medication administration for R12, R13, R14, R15, R16 and R17 were conducted on 4/18/2024 with LPN LL, RN MM, CMA AA and CMA KK. Medications were seen to be available and were administered as ordered, with no significant medication errors. 5. Verified via review of the Quality Improvement Data Collection Grid audit tools that were labeled as: 1) Were there medications not administered? 2) Was the MD notified? 3) If applicable, was order placed to hold medication? The audit tools were dated as completed 3/18/2024 through 4/17/2024. The tools included additional comments and follow-up information for any medications that were not administered. During an interview on 4/18/2024 at 12:25 pm, the ADON stated that she had assisted the DON in completing the audits, and so far, they had gone well. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/18/2024 at 2:50 pm, the Divisional Nurse confirmed implementation of the audit tool and the DON confirmed completing the audits with the assistance of the ADON. 6. Verified via review of clinical meeting documentation, dated 3/14/2024, a copy of the new Medication Aide to Nurse Communication form, and staff signature sheets. The staff signature sheets included six CMAs, six LPNs and five RNs, for a total of 17 nursing staff educated. During an interview on 4/18/2024 at 10:40 am, the Divisional Nurse stated that the total of 12 nurses included in this education were all full-time nurses. She confirmed that there were three additional nurses; one on LOA (with no return date specified) and two that worked prn (as needed). She confirmed that education would be completed by the DON with the additional nurses when they returned to work. During an interview on 4/18/24 at 12:50 pm, the Divisional Nurse clarified that the education was provided from 3/12/2024 through 3/14/2024. During an interview on 4/18/2024 at 2:50 pm, DON also confirmed that she initiated education on 3/12/2024 and it continued through 3/14/2024. During an interview on 4/18/2024 at 12:25 pm, ADON confirmed that the new process had been implemented. Staff interviews conducted on 4/18/2024 at 10:13 am with the Education/Infection Control Registered Nurse (RN) JJ, at 10:27 am with CMA/Certified Nursing Assistant (CNA) KK, at 10:47 am with the Resident Assessment Instrument (RAI) Director, at 11:00 am with LPN LL, at 11:10 am with the Wound Care Coordinator, at 11:25 am with RN Charge Nurse MM, at 11:37 am with CMA NN, at 12:00 pm with CMA AA, at 12:05 pm with CMA QQ, at 12:29 pm with LPN OO, at 2:13 pm with RN TT, at 2:21 pm with RN RR, and at 3:18 pm with LPN SS, confirmed they had received education regarding medication administration that included inquiry of unavailable medication with the pharmacy, obtaining from back up pharmacy, notifying the provider of unavailable medication and obtaining orders to hold until available or change and/or discontinue medication as outlined in the facility's policy titled Medication Unavailable for Administration. They also confirmed they received education on documentation for medication administration. 7. During an interview on 4/18/2024 at 10:40 am, the Divisional Nurse stated that the last full-time nurse (LPN PP) was educated on the evening of 4/17/2024. A review of the in-service signature sheet, labeled Hold medication order Education revealed that LPN PP had been educated on 4/17/2024. During the interview with the Divisional Nurse on 4/18/2024 at 10:40 am, she stated that there was one nurse on LOA (with no return date specified) and two nurses that worked on an as needed basis. She confirmed that education would be completed by the DON with the additional nurses when they returned to work. During an interview on 4/18/2024 at 2:21 pm, RN RR confirmed that she worked at the facility on an as needed basis and had received the in-service education from the DON. During an interview on 4/18/2024 at 2:50 pm the DON confirmed that education would be provided to newly hired RNs, LPNs, and CMAs during the orientation process by the nurse manager assigned to them at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115614	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee County Health and Rehabilitation	214 Main Street Leesburg, GA 31763

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Verified via review of ADHOC QAPI meeting documentation, dated 4/16/2024, that included signatures of the Administrator, DON, Divisional Nurse, and Medical Director. Also verified via review of the Quality Improvement Data Collection Grid, dated 4/16/2024, and labeled as Audits of abatement were reviewed. The form included the Administrator's signature. During a text exchange on 4/18/2024 at 1:41 pm, the Medical Director confirmed he attended the 4/16/2024 ADHOC QAPI meeting by phone. During an interview on 4/18/2024 at 2:50 pm the Administrator, DON, and Divisional Nurse confirmed the ADHOC QAPI meeting from 4/16/2024 and that the audit results were reviewed. The Administrator confirmed that the Medical Director attended via phone and came to the facility and signed the meeting documentation afterward. 9. All Corrective Actions were completed on April 16, 2024. 10. The facility alleges that the IJ is removed on April 17, 2024.