STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115039	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller Nursing Home	206 Grace St Colquitt, GA 39837

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 12273 Based on observations, resident and staff interviews, record review, and review of the facility's policy titled, Grievance Policy, the facility failed to ensure that six of 40 sampled residents (R) (R37, R59, R57, R62, R68 and R83) who participated in Resident Council (RC), received a response to their grievances. Specifically, the facility failed to provide a response to grievances and complaints about call lights over a six-month period. The deficient practice had the potential to negatively impact each resident's quality of life and/or dimmish feelings of self-worth for R37, R59, R57, R62, R68 and R83. Findings include: Review of the facility's policy titled, Grievance Policy, revised on 11/15/2016 revealed, Policy: To support each resident's right to voice grievances (e.g., those about treatment, care, management of funds, lost items, or violation of rights). A resident's representative, other family members or advocate may also voice grievances on the resident's behalf. The Nursing Home after receiving a complaint and /or grievance will actively seek a resolution and keep the resident/family member appraised of the progress toward resolution. Continued review revealed under, Procedure: 1) A resident/family may voice or write a complaint and/or grievance to any staff member at any time. 2) The staff member must report the complaint to their supervisor and the supervisor must complete the Complaint Form. The Complaint Form can be found at the Nursing Station, the Social Service Director's office, Director of Nurses' office, and the Administrator's office. 3) Information to be completed includes the person taking the complaint, date of complaint, name of person making complaint, discipline complaint referred to, and a specific description of the complaint. 4) The findings from the complaint investigation are also written, as well as the action taken. The person making the complaint must be informed of the results, and the form signed and dated at that time by the staff member informing the resident or family member of the resolution. Review of the RC meeting minutes showed that call lights had been identified as an on-going discussion at each meeting between June of 2024 through January 2025. The notes did not include any information about who or what problems or concerns were reported, nor did the meeting minutes identify that the facility acted on the grievances or responded to the resident council group. During a RC meeting held on 1/6/2025 at 11:54 am with six residents in attendance, R37, R59, R57, R62, R68, and R8 revealed they did not get a response from the facility about how their concerns with call lights would be addressed. R59 and R68 revealed that call lights had been an ongoing issue, and no one from the facility had responded to the groups concerns. (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: 115039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Miller Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Grace St Colquitt, GA 39837	

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Review of the electronic medical record (EMR) revealed R37 was admitted to the facility with diagnoses of but not limited to Parkinson's disease and seizure disorder. Review of the Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/26/2024 revealed R37 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating little to no cognitive impairment. 2. Review of the EMR revealed R59 was admitted to the facility with diagnoses of but not limited to Parkinson's disease and depression. Review of the Annual MDS assessment, with an ARD date of 11/8/2024 revealed R59 had a BIMS score of 15, indicating little to no cognitive impairment. 3. Review of the EMR revealed R57 was admitted to the facility with diagnoses of but not limited to anxiety and depression. Review of the Quarterly MDS assessment, with an ARD date of 11/14/2024 revealed R57 had a BIMS score of 14, indicating little to no cognitive impairment. 4. Review of the Quarterly MDS assessment, with an ARD date of 12/16/2024 revealed R62 had a BIMS score of 14, indicating little to no cognitive impairment. 5. Review of the Quarterly MDS assessment, with an ARD date of 11/14/2024 revealed R68 had a BIMS score of 14, indicating little to no cognitive impairment. 6. Review of the Quarterly MDS assessment, with an ARD date of 10/14/2024 revealed R83 had a BIMS score of 15, indicating little to no cognitive impairment. During an interview on 2/6/2025 at 12:10 pm with the Administrator revealed how grievances voiced by residents who attend the RC meetings were addressed. When a resident identified a grievance, the information would be forwarded to the department head to be investigated, and verbal feedback would be provided to the RC group. She confirmed there was no documentation to identify what was discussed with the council members informing the residents of the resolution.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Miller Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Grace St Colquitt, GA 39837	

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on resident, family, and staff interviews, record review, and review of the facility's policy titled, Grievance Policy, the facility failed to investigate and resolve grievances timely, and failed to report findings in writing to the complainant for one of 30 sampled residents (R) (R146). Specifically, there were two complaints filed for R146 with the same care allegation. The issue was not resolved until the second grievance was filed six months later and the complainants were not notified of findings and resolution. The deficit practice caused issues to be ongoing and the potential for unmet needs and dissatisfaction for R146. Findings include: Review of the facility's policy titled, Grievance Policy, revised 11/15/2016 revealed, Policy: To support each resident's right to voice grievances (e.g. those about treatment, care, management of funds, lost items, or violation of rights). A resident's representative, other family members of advocate may also voice grievance on the resident's behalf. The Nursing Home after receiving a complaint and/or grievance will actively seek a resolution and keep the resident/family member apprised of the progress toward resolution. The Grievance Official representative is Social Service . The person making the complaint must be informed of the results, and the form signed and dated at that time by the staff member informing the resident or family member of the resolution. The policy did not include provisions to provide anything in writing to the person making the complaint. Review of the electronic medical record (EMR) Face Sheet revealed R146 was admitted to the facility on [DATE] and was discharged to a different facility on 12/31/2024. Admission diagnoses included dependence on ventilator and quadriplegia (paralysis affecting all four limbs). Review of the Annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/14/2024 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating little to no cognitive impairment. R146 was impaired in range of motion (ROM) to both sides of her upper and lower extremities. R146 required meal set up for eating and was dependent on staff for the remaining Activities of Daily Living (ADL). 1. Review of the Complaint Log for February 2024 provided by the facility revealed a complaint was filed on 2/19/2024 regarding R146 by Family Member (F) (F146) related to nursing care. Review of the Complaint Form dated 2/19/2024 revealed the complaint alleged Certified Nursing Assistant (CNA)1 did not round regularly and R146 was reported to be raw because of it (not having her brief changed timely). The second concern related to washcloths being used for perineal care. The findings revealed, No rawness noted to peri-area. - Interviewed CNA's - washcloths being used to provide cleanliness to perineal after post BM [bowel movement]/urinary episodes. CNA inconsistent in rounding Q [every 2 hrs [hours] Action taken included, CNA educated/counseled on Q2hr rounds and as needed by resident. Educated to use wipes due to resident's preferences. The individual investigating the incident was Registered Nurse (RN)/Critical Care Coordinator (CCC)1 and the grievance was completed on 2/24/2024. There was a check next to Person making complaint has been informed of results with a resolution dated 2/24/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER: Miller Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 206 Grace St Colquitt, GA 39837	

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of CNA1's personnel file did not include documentation of counseling related to this incident (grievance 1). Review of the care plan revealed it was not updated with her preference for staff not to use washcloths for peri-care following the the first grievance. 2. Review of the Complaint Log for August 2024 provided by the facility revealed a complaint was filed by R146 on 8/5/2024 regarding nursing care. Review of the Complaint Form dated 8/5/2024 revealed R146 reported on 8/3/2024 that CNA2 used rags to wash her when she has asked her not to use rags on her buttocks. Findings from the investigation revealed CNA2 used washcloths for cleaning an incontinent episode. Action taken included planning R146's preferences to use wipes versus washcloths, educating staff to honor her preferences, and explanation to R146 and F146 why the washcloth was used. SW1 was documented as informing the complainant of the results of the grievance as noted by a check mark on the form on 8/6/2024. Review of the care plan, last reviewed/revised on 12/23/2024, revealed, Resident refuses to be cleaned with wash cloth during incontinent [sic] due to discomfort/sensitivity. Approaches included: Clean resident with wipes only per resident preference, use washcloth for cleaning as last resort; explain procedure to resident with a start date of 8/6/2024. During an interview on 2/5/2025 at 1:58 pm, F146 revealed that she and R146 had expressed concerns, and filed formal complaints, about provision of incontinence care for R146's by two CNAs. CNA1 did not provide timely incontinence care, was rough with wiping during incontinence care, ignored and did not address R146's needs. An example was once F146 came into the facility and R146 had not been changed for an extensive period. F146 reported this grievance, and confirmed she had not heard anything back, or provided anything in writing in response to formal complaints. F146 also had concerns with the provision of incontinence care by CNA2. During an interview on 2/6/2025 at 7:44 am with CNA2 revealed R146 was alert and oriented, dependent for incontinence care and brief changes. CNA2 remembered R146 did not want her to use washcloths for peri care and preferred wipes be used. CNA2 stated she had used a washcloth for bowel incontinence to remove excess bowel movement as it was more effective than using a wipe. During an interview on 2/6/2025 at 1:29 pm with Social Worker (SW)1 revealed they did not provide anything in writing to complainants about grievances and notified complainants verbally of. SW1 revealed R146's initial grievance occurred on 2/24/2024 related to CNAs not rounding regularly. A second grievance occurred on 8/5/2024 when CNA2 used wash cloths for peri care after R146 requested they use wipes. During an interview on 2/6/2025 at 1:55 pm, RN/CCC1 verified she investigated the grievance filed on 2/19/2024 by F146. F146 complained that the CNAs were wiping R146 with a wash rag and not using wipes, the wash rags were too rough and irritated her peri area. RN CCC1 revealed the results of grievances were reported back to the complainant verbally; nothing was provided in writing. During an interview on 2/6/2025 at 3:06 pm with the Director of Nursing (DON) revealed the results were reported to the individual who made the complaint orally. The DON stated the complainant could have a copy of the written grievance if they asked for it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Miller Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Grace St Colquitt, GA 39837	

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 - 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** 39857 [NAME] Based on observations, staff interviews, record review, and review of the Manufacturers information sheet titled, [Brand name of specialty bed manufacturer], the facility failed to obtain a Physicians order for one of 30 sampled residents (R) (R114) related to a specialty bed. Specifically, the facility failed to obtain a physician's order for use of a [name of bed manufacturer] specialty bed for R114 who was at risk for falls related to cerebral palsy, severe intellectual disability, and a history of falls. Findings include: Review of the Manufacturer's [named specialty bed manufacturer] information sheet provided by the facility revealed [named specialty bed manufacturer] is a domestic manufacturer of custom safety beds, featuring safety side rails, designed to address falls and entrapment for those with physical and cognitive disabilities. Review of the electronic medical record (EMR) revealed R113 was admitted to the facility on [DATE] with diagnoses including cerebral palsy. Review of R114's current physician orders dated 2/5/2025 revealed no order for the [named specialty bed manufacturer. Review of the Annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/26/2024 under the RAI (Resident Assessment Instrument) tab revealed R114 was rarely or never understood, and the Brief Interview for Mental Status was not conducted. R114 was 53 tall (4'5) and weighed 73 pounds. Under the Physical Restraints section, bed rails were not checked as being used. Review of the care plan, dated 11/14/2023, revealed R114 has specialty bed provided by family, R114 is accustomed to this bed from home. The goal was Maintain home life environment for resident to decrease agitation. Approaches in total were Monitor resident for agitation while in bed. Place resident in home like bed safely at bedtimes. Continued review of the care plan revealed Resident at risk for falling R/T [related to] cerebral palsy and severely intellectually impaired. Interventions included: [R114] is in personal specialty crib bed with side panels up while in bed. Observations on 2/4/2025 at 5:19 pm, on 2/5/2025 at 3:44 pm, and on 2/6/2025 at 8:06 am revealed R114's [named specialty bed manufacturer] was a bed with four solid panels (on each side of the bed and at the head and foot of the bed) extending approximately 36 inches above the mattress. The solid panels were in an up position when R114 was in bed per observations. R114 was small in stature and was observed to have movement of her limbs. During an interview on 2/5/2025 at approximately 2:00 pm with the Assistant Director of Nursing (ADON) 3 revealed he was a family member and the emergency contact for R114, and the bed was the same one that R114 used at home prior to coming to the facility. The ADON 3 stated R114 spun around, scooted, rolled over, moved constantly and the bed design kept her from falling out of bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller Nursing Home	206 Grace St Colquitt, GA 39837

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 - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/5/2025 at 4:45 pm, Certified Nursing Assistant (CNA) 3 stated R114 required total care, her normal schedule of getting up into a [named specialty chair] around 7:00 am until around lunch time and spent the remainder of the day in her specialty bed. CNA 3 verified R114 was not able to put the slats of the bed down. CNA 3 stated R114 had used the specialty bed since she was admitted to the facility. During an interview on 2/6/2025 at 5:04 pm with ADON 1 revealed the specialty bed had been in use since R114 was admitted to the facility on [DATE]. ADON 1 stated R114 was accustomed to using the bed from home and the goal was to decrease agitation and fussiness and keep R114 from rolling out of bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Miller Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Grace St Colquitt, GA 39837	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15406 Based on observations, staff interviews, record review, and review of the facility's policy titled, Dietary Procedure Manual, the facility failed to ensure dietary areas were maintained in a sanitary manner. Specifically, food and supplements were not labeled properly, frozen meats were exposed to air, chemicals were stored with food, handwashing could not be completed without contamination of one's hands, floors were observed with built up substance, and the facility failed to use a sanitizer on kitchen surfaces. The deficient practice had the potential for transmission of food borne illness, and potential to affect 60 of 153 residents who received an oral diet served from the kitchen. (105 residents received partial to total nutrition needs via feeding tubes). Findings include: Review of the facility's policy titled, Dietary Procedure Manual, review date [DATE], under Infection Control-Food Preparation revealed, B. Patient Service: 5. All foods stored in diet kitchen refrigerator should be covered and labeled, dated or in pre-packaged containers . 6. Covered food should be discarded after 72-hours if not consumed . Food Storage: 1. All foods in the refrigerators are covered, labeled, and dated if not in original container . 6. Proper storage techniques including containers, temperatures, coverings, and length of time should be known and practiced by all . Food Storage: 19. Cleaning supplies are stored separately from food supplies . Cleaning: 4. Equipment and work surfaces are cleaned and sanitized before and after each use . 5. Floors are swept and mopped daily . 8. The counters in serving and preparation areas are cleaned with germicidal solution at each workstation after each use . Perishable Food Item Storage-Procedure: Leftover food items are stored in covered containers. Each container is labeled as to the contents and dated. 1. Observation and interview on [DATE] at 10:00 during the initial tour of the dietary department with the Food Service Supervisor (FSS), he revealed the main kitchen was in the process of being remodeled so the food service operation was spread out in several locations. Dietary staff were preparing meals in the physical therapy (PT) kitchen located a couple blocks away. There was a semi-truck freezer located next to the PT kitchen where frozen food was stored. The walk-in refrigerator located in the main kitchen in the hospital was still in use. There was also a makeshift kitchen set up in the facility with a steam table for tray line meal service, refrigerator/freezers and storage area. The following concerns were noted during the initial tour on [DATE] from 10:00 am to 11:02 am: a. Observation and interview with the FSS of the walk-in freezer truck revealed there were two boxes of meat, one bacon and one of pork chops that were not closed. The boxes had been opened and the plastic bag within the box had not been sealed exposing the entire top contents of the meat in the boxes to air. The FSS verified the meat was exposed to air and stated it should be completely covered/sealed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Miller Nursing Home	206 Grace St Colquitt, GA 39837

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Observation and interview in the PT kitchen revealed a small storage room that contained food items such as canned and boxed of food. There were 4 gallons of bleach stored in the room with the food. The FSS verified the bleach should not be stored with food. The only garbage can in the PT kitchen was a 55 gallon can with a lid on it which required touching the potentially soiled garbage can lid with clean hands, which was verified by the FSS. The FSS stated they had a foot operated can in the old kitchen which prevented staff from soiling their hands, but it had not made it over to this temporary kitchen. Also, in the PT kitchenwas a bag of opened and thawed chicken tenders in the refrigerator that was unlabeled and undated. The manufacturer's expiration date was [DATE]. The FSS revealed their system for labeling and dating was to go by the manufacturer's expiration date, and leftovers they would keep for no more than three days. The FSS verified the manufacturer's date on the chicken showed the food was expired, and revealed dietary staff were supposed to label foods with the name of the food and the date the food expired. There was a container of leftover chili dated [DATE]; the FSS verified it was more than three days old. There were two packages of turkey lunch meat (per the FSS) in the reach-in refrigerator, one package opened and the other one not. Neither were labeled with the food item or date. c. Observation and interview in the walk-in refrigerator in the hospital revealed there was black grime on the floor along the edge of the wall and floor and accumulated brown crusty debris in the corner. There was a box half full of individually packaged four ounce [brand name] nutritional shakes in the manufacturer's box which was dated [DATE]. The FSS verified the shakes were past the expiration date. On each carton instructions read, use thawed product within 14 days. The FSS stated they used the manufacturer's expiration dates for the shakes, and she was not aware of the 14-day shelf life once the product was pulled from the freezer and placed in the walk in. 2. Observation and interview on [DATE] from 10:35 am to 11:48 am with the Food Service Manager (FSM) the following concerns were noted: a. Station Five snack area refrigerator contained approximately 20 cartons of [brand name] nutritional shakes. There were no dates to indicate when the shakes had been pulled out of the freezer and thawed. The FSM stated they received the [brand name] nutritional shakes frozen and pulled out what they needed and placed them in refrigeration. The FMS verified the label on the shakes indicated they should be used within 14 days of being thawed. b. The walk-in refrigerator in the hospital kitchen was in the same condition noted on [DATE]. There was black grime and brown crusty debris in the corners and along the walls. The FSM verified it needed to be cleaned. c. The PT kitchen had a bag of unidentified small pieces of meat dated [DATE]. The FSM verified it was a bag of bacon bits, it should be labeled with the food item and date, and it should be disposed of. The FSM stated their policy was to keep leftover food no more than three days, otherwise, they went by the expiration date on the box. The FSM stated staff should label foods with the date it was placed in refrigeration and the date it should be used by. During an interview, the FSM was asked what sanitizer they used for kitchen surfaces. The FSM showed the surveyor a spray bottle of the product [brand name of product]. The FSM stated that it was the product they used to clean the tray line and kitchen surfaces. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/07/2025
NAME OF PROVIDER OR SUPPLIER Miller Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 206 Grace St Colquitt, GA 39837	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the label of the product and the Manufacturer's Safety Data Sheet for the product [brand named product] provided by facility revealed the product was a cleaning product and not a sanitizer. Ingredients included sodium dodecylbenzene sulfonate, sodium poly (oxyethylene) dodecyl ether sulfate, and organic sulfonic acid salt.