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	05/17/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, family and staff interviews, record review, and review of the policy titled, Residents' Rights, the facility failed to protect and promote the rights of one of 71 sampled residents (R) (R88). This deficient practice had the potential to violate the residents' preferences and religious culture.Findings include:Interview on 05/16/2026 at 12:25 PM with Social Services DD confirmed that R88's hair was cut without prior permission. She stated that a nightˆshift nurse cut the hair. She was not sure why the nurse cut the hair but suggested it may have been for cleanliness. She confirmed that the family should have been contacted, and was not, until after the resident's hair was cut.Interview on 05/16/2026 at 12:36 PM with the Director of Nursing (DON) revealed and confirmed that Licensed Practical Nurse (LPN) EE, on the night shift, cut the resident's hair. She stated that it was reported to the nurse by a Certified Nursing Assistant (CNA) that the resident had bugs in her hair. After speaking with the family, it was revealed that the haircut was a cultural concern and that this was the reason the family did not want the haircut. She stated that the nurse was reprimanded and received disciplinary action, because of the situation. The DON confirmed that the nurse did not reach out to the family to inform them prior to the haircut.Observation on 05/16/2026 at 12:50 PM of R88 revealed that the resident's hair was cut. She was observed to have a short afro hairstyle. R88 was on a ventilator with tracheostomy and was nonverbal.Interview via phone on 05/16/2026 at 4:26 PM with LPN EE revealed, she was providing personal care to R88 and observed that the resident's hair was dirty and matted. She stated she saw blackˆlooking bugs in R88's hair and made the decision to cut the resident's hair. LPN EE confirmed that she cut R88's hair without obtaining permission from the family. She stated she notified her supervisor, and that her supervisor informed the family. LPN EE stated she was suspended for three days.Interview via phone on 05/16/2026 at 6:25 PM with the family of R88 revealed that she had received a call from the facility informing her that R88's hair was cut. The family of R88 stated that R88 was religious, nonverbal, but if she could speak, she would have refused to have her hair cut. The family of R88 stated she was R88's voice.Review of the electronic medical record (EMR) revealed that R88 was admitted to the facility on [DATE], with pertinent diagnoses including, but not limited to, acute and chronic respiratory failure with hypercapnia (primary), dependence on a respirator/ventilator, contracture of muscle in multiple sites, and contracture of the right wrist.Observation of a photograph on the face sheet revealed R88 wore a large purple bonnet which covered her hair.Review of R88's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) was not conducted due to her non-verbal status.Review of the care plan dated 01/19/2026, revealed a problem that R88 had dandruff and required shampoo treatment on Mondays, Wednesdays, and Fridays. The goal was for the resident's hair to remain clean through the review date. The approach directed staff to wash the resident's hair with selenium sulfide on Mondays, Wednesdays, and Fridays. The approach also documented that the family requested that the resident's hair not be cut.Review of R88's physician orders documented the following: Antiˆ Dandruff (selenium sulfide) shampoo, overˆtheˆcounter (OTC), 1% {percent} strength, with an amount of one application, to be applied topically. Special Instructions: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Apply to the scalp with bath three times per week. Frequency: Once a day on Monday, Wednesday, and Friday.Review of the progress note dated 06/10/2025 at 11:06 AM, documented that a headˆtoˆtoe skin assessment was completed. The assessment included a description of her hair, which was described as a dread lock hair style and the dreads measured approximately 30 to 36 inches long. The posterior portion of the hair was matted. Staff were unable to fully assess the head and hair to determine the scalp condition.Review of LPN EE Notice of Suspension, dated 01/20/2026 documented an infringement of resident rights by cutting a resident's hair without the resident's or family's consent and failing to provide notification, as well as failing to report an infection risk (bugs in hair) to the supervisor or provider in a timely manner. The documented expectation was that the employee speak with the family prior to cutting a resident's hair and report all reportable situations to the supervisor, manager, or provider promptly, and the stated consequence for repeated action was termination.Review of the complaint form dated 01/20/2026 documented that the family of R88 filed a complaint regarding a nurse that cut R88's hair dreads without contacting the family, and the family was upset that the dreads were disposed of, as confirmed through the investigation. The resident's hair was cut and the dreads were discarded; the nurse responsible stated she was washing the resident's hair and noticed small bugs, and she admitted she did not notify the family or obtain consent. No bugs were found in the resident's room or on the resident during assessment. Actions taken included bringing in pest control to assess and spray the room, providing discipline and education to the nurse, and removing her from providing care to R88. The facility also initiated 100% staff education during monthly staff meetings and updated social history admission forms to include more cultural preferences. Followˆup was completed on 01/31/2026, and the family remained upset about the situation and requested a transfer to a facility in another state. It was additionally noted that the complaint form listed Social Services DD as the individual who took the complaint, and the Administrator's signature also appeared on the form. Review of the policy titled , RESIDENT'S RIGHTS documented The Omnibus Budget Reconciliation Act (OBRA Law), passed by Congress in 1987 and amended in 1989, requires that a nursing facility (nursing home) must protect and promote the rights of each resident (an individual living in a nursing facility), including each of the specific rights listed below. The nursing facility must read you your Federal rights on the day of admission. You also must be informed of your rights under the Georgia Law (Longˆ Term Care Facility Resident's [NAME] of Rights). Freedom of Choice . You have the right to be informed before there are changes in your care or treatment which may affect your wellˆbeing, to take part in the planning of your care and treatment or changes in your care and treatment, and the right to accept or refuse treatment, unless you have been adjudged incompetent.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review and review of the facility's policy titled, Gastrostomy Tube Feedings, the facility failed to provide appropriate care for a gastrostomy tube (G-tube) (tube inserted into the stomach for nutrition) for one of 71 sampled residents (R) (R83). The deficient practice increased the risk of associated complications for R83.Findings include:Review of the facility's policy titled Gastrostomy Tube Feedings, reviewed 01/20/2023, documented Procedure: The initial gastrostomy tube is inserted in the surgical department by a physician. Position of resident. If resident has gastrostomy, use caution with gastrostomy tube .Review of the facility's electronic Medical Records (EMR) documented R83 was admitted to the facility on [DATE], with the diagnosis included, but not limited to, dysphagia.Review of the Annual Minimum Data Set (MDS) dated [DATE], documented Section C (Cognition) Brief Interview for Mental Status (BIMS) was not conducted as R83 was rarely/never understood, and Section K (Swallowing/Nutritional Status) R83 was coded for tube feeding.Review of the care plan dated 05/07/2026, documented which included, but was not limited to, that R83 required tube feeding due to dysphagia with a goal that R83 will not exhibit signs of complications from feeding tube or enteral feeding solution through the next review and an intervention of total care in eating. enteral formula per MD {physician} order.Review of Physician's Orders dated 04/27/2026, documented which included, but was not limited to, ENTERAL DIET: Mix (500 milliliters [ml] of Osmolite 1.5 kilocalorie (kcal) with 300mL of water in 1 liter bag) via J tube {jejunostomy tube inserted directly into the jejunum} @ {at}100 mL/hr {100 milliliters per hour.} Special Instructions: If unavailable, may substitute with Osmolite 1.2 kcal. Bag is to be changed every 8 hrs {hours.} Every Shift 07:00 AM- 07:00 PM, 07:00PM- 07:00 AM. Observation and interview on 05/15/2026 at 11:53 AM revealed, R83 was sitting in a recliner at station two hallway next to the wound care nurses' station. Further observation revealed Preceptor and Licensed Practical Nurse (LPN) AA pushed a pole with tube feed and pump to R83 and used her gloved hands to plug the G-tube machine into the wall socket. There was another G-tube machine plugged in the same socket and LPN AA removed the other plug and reinserted it into the other socket then plugged the G-tube machine into the socket. LPN AA used the same pair of gloves which she used to plug the machine into the socket to connect the tube feed to R83's G-tube. LPN AA confirmed she used the same pair of gloves to plug the G-tube machine into the wall socket and then connected the tube feed to R83's G-tube. She stated she should have changed her gloves because the plug was not clean and she handled the plug with the same gloves she used to attach the feed to R83's G-tube. LPN AA stated she had to hold R83's G-tube and place her hand on the G-tube area at the tip which is inserted into the G-tube in order to insert the tube. She stated she should have changed her gloves after she plugged in the machine and before she touched his G-tube because R83 could get G-tube complications such as infections.Interview on 05/16/2026 at 11:33 AM with Registered Nurse Supervisor (RNS) CC confirmed that the same pair of gloves should not be used to plug in the feeding machine and worn to attach the tube to the resident's G-tube. She stated the plugs and socket were dirty and had germs on them, so the gloves should have been changed. RNS CC further stated it was improper handling of the G-tube and R83 could have complications of the G-tube such as infection.Interview on 05/17/2026 at 10:06 AM with the Director of Nursing (DON) confirmed, the protocol was that the tube should be connected to the resident first, and then the G-tube machine should be plugged in afterwards. The DON stated the connecting of the tube feed was a clean process and proper handling of the G-tube would be for the nurse to go from clean to dirty. She stated the G-tube should have been attached first and then the machine plugged in afterwards since the plug was considered dirty. The DON further stated a complication of G-tube was introducing bacteria into the G-tube which could also introduce infection to R83.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and review of the facility's policies titled, Hand Hygiene, Infection Control (Donning and Doffing PPE {personal protective equipment}), and Infection Control (Scope of Service), the facility failed to implement infection control practices for one of six sampled residents (R) (R17), reviewed for infection control. Specifically, staff failed to sanitize hands between glove changes related to care of an intravenous (IV) access device (flexible, long tube inserted into a vein for long term use.) This deficient practice increased the risk of clinical complications for R17. Findings include:Review of the facility's policy titled, Hand Hygiene, reviewed March 2026, documented Procedure: If hands are not visibly soiled, use an alcohol-based hand rub for decontaminating hands in the situations listed below. After removing gloves.Review of the facility's policy titled, Infection Control (Donning and Doffing PPE), reviewed March 2026, documented DOFF (Take off) PPE: and bullet number four Perform hand hygiene using an alcohol-based hand sanitizer immediately after removing all PPE.Review of the facility's policy titled, Infection Control (Scope of Service), reviewed March 2026, documented Scope: Methods to assess and meet resident care needs: Systemic, coordinated and continuous approach to improving performance, focusing on surveillance, prevention and control of infections throughout the facility; assure functioning, coordinated process to reduce the risk of nosocomial infections in patients and staff; education of personnel regarding infection control practices; increase community education regarding communicable diseases; compliance with regulatory agency's requirements.Review of the facility's electronic Medical Records (EMR) documented R17 was admitted to the facility on [DATE], with diagnosis which included, but not limited to, bacteremia (bacteria in the blood).Review of the Quarterly Minimum Data Set (MDS) dated [DATE], documented Section C:(Cognition) Brief Interview for Mental Status (BIMS) was not conducted, because R17 was rarely/never understood, and Section O:(Special Treatments, Procedures, and Programs), documented R17 had IV access and received IV medication.Review of care plan dated 03/10/2026, included but was not limited to, R17 had a left femoral peripherally inserted central catheter (PICC) line, with a goal that the PICC line will remain patent and free from signs and symptoms (s/s) of infection, and approach was to change PICC line dressing, using sterile technique, per nursing home (NH) protocol. Review of Physician's Orders dated 02/20/2026, documented which included, but not limited to, Change PICC-line dressing using sterile technique as needed (prn). Change anti-reflux valve with each prn dressing change. As needed PRN.Observation on 05/16/2026 at 11:01 AM during R17's midline dressing change revealed, Registered Nurse Supervisor (RNS) CC changed her gloves and did not sanitize nor wash her hands between glove change. RNS CC did not sanitize her hands between a glove change three times during the procedure: after she removed old outer dressing, after she removed old inner securement dressing and after cleaning the midline site.Interview on 05/16/2026 at 11:05 AM with RNS CC, confirmed she did not wash her hands nor use hand sanitizer between glove changes. She stated she changed her gloves and she should have washed her hands or hand sanitized between glove change and she did not. RNS stated that when she did not wash her hands or hand sanitize between glove changes, it could cause spread of infection, cross contamination and spread of germs to R17.Interview on 05/17/2026 at 9:47 AM with Nurse Practitioner/Infection Preventionist (NP/IP) confirmed that hand hygiene was always to be done prior to putting on gloves and when gloves were removed. He stated hand hygiene was very important and when hand hygiene was performed it included the use of hand sanitizer or soap and water. The NP/IP further stated that when a central line dressing was done it was important to perform hand hygiene during glove changes. He stated that when hand hygiene was not performed between glove changes, it could introduce infectious agents/pathogens to the residents and they could become ill.Interview on 05/17/2026 at 10:06 AM with the Director of Nursing (DON) confirmed, the facility's protocol was that staff should sanitize their hands on entering the residents' room and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the signage is there to explain what PPE was needed. The DON stated that anytime they change gloves, they should hand sanitize in between. Once the gloves came off, the staff needed to perform hand hygiene. The DON stated the EMR system generated orders called PICC lines which were used for all central lines including midlines. A negative outcome for the resident was an increased risk of introducing infection to the resident and the resident could have a bacteremia infection.