STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115272	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joe-Anne Burgin Health and Rehabilitation	321 Randolph Street Cuthbert, GA 39840

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03115 Based on record review, interview and review of the facility's policy titled, Advance Directives, the facility failed to ensure two of 30 residents (R) (R54 and R31) code status was accurately reflected in the electronic medical record (EMR). As a result, the residents' code status had the potential to not be honored in the event they would have coded. Findings include: Review of the facility's policy titled, Advance Directives with a review date of [DATE], stated, Each patient with decision making capacity has the right to make their own decisions related to their medical care . including the right to refuse or alter treatment plans, to accept or refuse medical or surgical treatment .and formulate advance directives. 1.Review of R54's EMR revealed she was coded as a Do Not Resuscitate (DNR) on the EMR's dashboard. R54 had a physician's order in the EMR under the Orders tab dated [DATE] for Allow Natural Death (AND) - Do Not Attempt Resuscitation (DNR). Review of a document titled Physician Orders for Life-Sustaining Treatment (POLST) signed by the responsible party and dated [DATE] and signed by the physician on [DATE] indicated Attempt Resuscitation (CPR) marked in section A of the form indicating the resident's wishes were to be resuscitated in the event they were nonresponsive. Interview on [DATE] at 3:41 pm, Licensed Practical Nurse (LPN)1 and Certified Medication Aide (CMA) 1 stated that if R54 was found nonresponsive or coded, they would check the EMR dashboard on the computer screen where it stated DNR, and they would not attempt CPR. Interview on [DATE] at 3:45 pm, Registered Nurse (RN) 1 stated that if R54 was found nonresponsive or were to code she would check the EMR dashboard on the computer screen where it stated DNR, and she would not attempt CPR. On [DATE] at 3:48 pm the information was reviewed with the Division Nurse Consultant (DNC), the Administrator, and the Director of Nursing (DON). The DON and DNC both checked the EMR and verified the above findings. The Social Worker (SW) was present during the interview, and she stated she spoke to the daughter and the daughter stated she wanted the facility staff to do CPR if her mother coded even though she was on hospice. (continued on next page)

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
	115272	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joe-Anne Burgin Health and Rehabilitation	321 Randolph Street Cuthbert, GA 39840

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on [DATE] at 4:47 pm the DNC and Administrator stated they called the daughter, and she wanted her mother to be a DNR with her being on hospice. They stated the daughter was coming into the facility to sign the DNR paperwork. Interview on [DATE] at 5:32 pm, R54's daughter/ responsible party stated her mother wanted to be full code until today ([DATE]) when she arrived at the facility and signed the paperwork changing her mother from a full code to a DNR code status. She stated she decided to change the code status because her mom is now cognitively unable to make decisions, and declining in health. She does not want her mother to suffer if CPR were to be attempted. 2. Review of R31's EMR revealed admitted on [DATE] with diagnosis of acute and chronic respiratory failure with hypoxia. Review of the EMR revealed a document titled POLST located in the Advanced Directive tab of the EMR signed by the resident and the physician and dated [DATE]. Under section A Code Status of the document the resident marked Allow Natural Death (AND)-Do not Attempt Resuscitation. Review of the Dashboard of the EMR and the physician's orders with a start date of [DATE] indicated the resident was Full Code. The resident's care plan for Advanced Directive located in the care plan tab of the EMR stated Full Code Status with an onset date of [DATE]. Interview on [DATE] at 3:41 pm, LPN1 and CMA1 stated they would check the EMR, dashboard on the computer screen where it stated, Full Code and they would do CPR. Interview on [DATE] at 3:45 pm, RN1 stated for R31 if she coded, she would check the EMR, dashboard on the computer screen indicates Full Code she would start CPR. On [DATE] at 3:48 pm the information was reviewed with the DNC, the Administrator, and the DON. The DON and DNC both checked the EMR and verified the dashboard and physician's order should have been marked Allow Natural Death (AND)-Do not Attempt Resuscitation. After the information was shared the code status in the dashboard and the physician's orders were changed to reflect the resident's wishes to be a DNR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115272	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joe-Anne Burgin Health and Rehabilitation	321 Randolph Street Cuthbert, GA 39840

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51678 Based on observation, interview, facility policy review titled, Pharmacy Services Insulin Administration, and review of manufacturer's instructions, the facility did not ensure that one of one Licensed Practical Nurse (LPN)2 had primed an insulin pen prior to dialing the ordered dose for one of one (Resident (R)227). In addition, LPN2 did not keep the needles in R227's arm for 10 seconds. Not priming an insulin pen prior to dialing the ordered dose and the failure to keep the needle in the arm for 10 seconds has the potential to reduce the insulin dose which could have affected R227's blood glucose. Findings include: Review of the facility's policy Pharmacy Services Insulin Administration dated 2025 revealed, Prime the pen and clear air from the needle. Turn the dose knob at end of pen to 1 or 2 units. Hold the pen with needle upward. Press dose knob while watching for insulin drop or stream to appear. Repeat, if needed, until insulin is seen at tip. The dial should be back at zero after priming complete .Needle should remain in subcutaneous tissue for 10 seconds to allow all of the medication to be administered properly. Review of the manufacturer's Instructions for use Humalog ([NAME]-ma-log) KwikPen(R) (insulin lispro) revealed, Prime before each injection. Priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. Observation on 2/13/2025 at 11:48 am revealed Licensed Practical Nurse (LPN) 2 retrieved R227's Humalog insulin pen from the medication cart. She dialed the pen to four units of insulin and then placed a new needle. She went ahead and injected the insulin in R227's left arm. She only left the needle in for approximately six seconds.] Interview on 2/13/2025 at 12:15 pm, LPN 2 stated that she was not aware that an insulin pen needle system should have been primed with two units prior to dialing the four units. LPN2 also acknowledge that she had not left the needle in the arm for the 10 seconds. Interview on 2/13/2025 at 1:00 pm with the Director of Nursing (DON) and the Divisonal Nurse Consultant, both stated that the nurses have all been educated on using the insulin pens and about priming the insulin pen first. Interview on 2/14/2025 at 9:00 am, Registered Nurse (RN) 1 revealed when giving insulin with an insulin pen it was required to prime the pen, after the needle unit had been placed, with two units of insulin. Priming the pen ensured the resident received the correct dose of insulin ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115272	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joe-Anne Burgin Health and Rehabilitation	321 Randolph Street Cuthbert, GA 39840

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 51678 Based on observation, interview, review of the facility's policy titled, Disinfecting Point of Care Devices and manufacturer's instructions, the facility did not ensure one of two nurses (Licensed Practical Nurse (LPN)4 sanitize the glucometer between (Residents (R)72, R227, and R228) use. The failure to ensure the glucometer had been disinfected between residents increased the risk of residents' contracting a blood borne disease. Findings include: Review of the facility's policy for Disinfecting Point of Care Devices dated 12/27/2024 revealed the center would ensure that reusable Point of Care devices, including glucose meters, were to have been cleaned and disinfected per manufacture's guidelines after each use. Review of the (Company Name) ProView Meter manufacturer's Caring for the Meter instructions indicated, Glucose meters used in a clinical setting for testing multiple persons must be cleaned and disinfected between patients the meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. The disinfection process reduces the risk of transmitting infectious diseases if it is performed properly. Observation on 2/13/2024 at 11:18 am. LPN4 removed the glucometer from the top drawer of the medication cart and placed the glucometer without sanitizing it on a clean tissue she had laid on top of the medication cart. Before she went into Resident (R)72's room she wiped the glucometer with an alcohol wipe and placed the glucometer back on the same tissue. LPN4 carried the glucometer into R72's room with the tissue wrapped around it and set it on R72's overbed table. She then used the glucometer to complete R72's accu chek. LPN4 brought the glucometer out of R72's room wrapped in the tissue, set the glucometer on the medication cart, took a clean tissue, and set the glucometer on that tissue without sanitizing the glucometer. LPN4 cleaned the glucometer with an alcohol wipe. LPN4 used the same glucometer for R227 and R228 and only wiped the glucometer with an alcohol wipe between residents' use of the glucometer. Review of R72's diagnoses under the Summary tab in her electronic medical record (EMR) revealed she did not have a communicable disease. Review of R72's February 2025 Medication Administration Record (MAR) revealed the order date for accu chek was 1/13/2025. Review of R227's diagnoses under the Summary tab in her EMR revealed she did not have a communicable disease. Review of R227's February 2025 MAR revealed the order date for accu chek was 2/06/2025. Review of R228's diagnoses under the Summary tab in her EMR revealed she did not have a communicable disease. Review of R228's February 2025 MAR revealed the order date for accu chek was 2/06/2025. Interview on 2/13/2025 at 11:55 am, LPN4 stated that she had not maintained the proper infection control procedures when she had used the glucometer between residents' use. She said she was told to use alcohol wipes to clean the glucometer between residents' use instead of the purple-top Santi-cloth wipes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115272	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joe-Anne Burgin Health and Rehabilitation	321 Randolph Street Cuthbert, GA 39840

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/13/2025 at 1:00 pm with the Director of Nursing (DON) and the Divisional Nurse Consultant both stated that the glucometers were to be disinfected between residents with a purple-top Sani-cloth wipes. They agreed if the glucometer had been set on the medication cart and then on the clean barrier it would have contaminated the barrier. During a phone interview with the facility Medical Director (MD) on 2/14/2025 at 3:56 pm, the MD stated that he felt the alcohol swab and the antimicrobial cleaner could be interchangeable with the same sanitizing result. He stated, . as long as it was cleaned between residents and there are no communicable diseases in the building, I expect the outcomes would be the same with either cleaner.