STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115667	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colquitt Regional Senior Care & Rehabilitation	101 Cobblestone Trace SE Moultrie, GA 31768

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 09262 Based on interview, record review, and review of the facility's policy titled, Transfer or Discharge documentation, the facility failed to ensure a written transfer/discharge notice with required content was provided prior to being transferred for three residents (R), R32, R1, R8, and the resident representatives (RR). In addition, the facility failed to provide the State LTC (Long Term Care) Ombudsman office with notification of residents who transferred or discharged . The deficient practice had the potential for residents to be inappropriately transferred or discharged by not being informed of their rights and appeal options. The sample size was 22 residents. Findings include: Review of the facility's policy titled, Transfer or Discharge documentation dated 10/2022 revealed, .4 .when a resident is transferred .from the facility, the following information will be documented in the medical record .b. That an appropriate notice was provided to the resident and /or legal representative . 1. Review of R32's electronic medical record (EMR) Progress notes tab revealed on 7/14/2024 at 11:45 pm, Resident vomit coffee ground x (times)3 and c/o (complaint of) abdominal pain Recommendations: New order to ER (emergency room) for tx (treatment)/eval (evaluation). On 7/15/2024 at 00:09 AM (12:09 am) .Call 911 Further review of the EMR Progress notes revealed no documentation that the resident and Resident Representative (RR) were provided the transfer notice. 2. Review of R1's EMR Progress notes tab revealed on 5/22/2024 at 1:35 am, Resident continues to run a fever along with vomiting. Resident's heart rate continues to stay up. Resident sent out to ER. Further, review of the EMR Progress notes revealed no documentation that the resident and RR were provided the transfer notice. 3. Review of R8's EMR Progress Notes tab revealed, on 1/24/2024 at 8:15 am, called to resident's room by CNA (Certified Nursing Assistant). Resident is not feeling well, she says she has pneumonia again. On 1/24/2024 at 9:28 am, EMS (Emergency Medical Service) here to take resident to the ER for evaluation. Further, review of the EMR Progress notes revealed no documentation that the resident and RR were provided the transfer notice. (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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/2024 at 5:37 pm, the Administrator provided R32, R8 and R1's Transfer form that was mailed to each resident's RR. Review of the Transfer form did not include a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State LTC Ombudsman. Interview on 8/13/2024 at 9:41 am, the Administrator reviewed R32, R1 and R8's Transfer forms and confirmed that the transfer forms did not include the resident's appeal rights and the name/address of the State Ombudsman office Interview on 8/13/2024 at 10:48 am, the Administrator revealed that prior to May 2024 the facility was not sending transfer notices to the State LTC Ombudsman, but they were now. The Administrator provided the May 2024, June 2024, and July 2024 lists that were sent to the Ombudsman's office. Review of the list revealed that R8's transfer to the hospitalER on [DATE] was not included on the May 2024 list of discharges and transfers to the Ombudsman. Further review revealed R32's transfer to the hospitalER on [DATE] was not included on the July 2024 list. Further interview after reviewing the May and July 2024 lists, the Administrator confirmed that the facility was only sending hospital transfers to the Ombudsman for residents that did not return to the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693 Based on interview, record review, and review of the facility's policy titled, Antipsychotic Medication Use, the facility failed to implement a care plan for monitoring the use of psychotropic medications for two of two residents (R) R154 and R31 reviewed for psychotropic medications. This failure could result in unwarranted use of psychotropic medications and unmanaged medication side effects. The sample size was 22 residents. Findings include: Review of the facility's policy titled, Antipsychotic Medication Use, dated 8/2022, revealed, .The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others .based on assessing the resident's symptoms and overall situation, the physician will determine whether to continue, adjust, or stop existing antipsychotic medication . 1. Review of R154's undated Face Sheet located under the Profile tab in the electronic [NAME] record (EMR) revealed R154 was admitted to the facility on [DATE] with the diagnoses of intraarticular of the lower end of right wrist, major depressive disorder, bipolar disorder, and Alzheimer's disease. Review of R154's Admission Minimum Data Set (MDS) could not be completed due to this MDS being In Progress. Review of R154's Physician Orders revealed orders dated 8/09/2024 for Aripiprazole 10 mg (milligrams) by mouth daily for mood disorders and escitalopram oxalate 20 mg by mouth daily for depression. Review of R154's Care Plan dated 8/9/2024 revealed R154 was at risk for mood issues due to having bipolar depression/anxiety. Interventions were, administer my medications as ordered, observe for tolerance/effectiveness and possible adverse side effects. Report to physician/nurse practitioner as indicated .notify the physician/nurse practitioner if worsening in my mood is observed . Review of R154's MAR (Medication Administration Record) dated 8/2024 revealed no monitoring of side effects of the medications given, or of worsening behaviors being exhibited by the resident. During an interview on 8/14/2024 at 9:40 am, the Director of Nursing (DON) confirmed there was no monitoring of side effects or behaviors of the psychotropic medications R154 was receiving. 2. Review of R31's undated Admission Record, revealed R31 was admitted to the facility on [DATE]. R31's diagnoses included major depressive disorder, recurrent severe without psychotic features. Review of a Quarterly MDS with an ARD (Assessment Reference Date) of 7/6/2024 indicated R31 had a Brief Interview for Mental Status (BIMS) score of 14 indicating R31 was cognitively intact. The MDS also indicated R31 had taken an antidepressant and antianxiety agent during the last seven days prior to the ARD. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R31's active Orders revealed an order dated 5/18/2024 for Celexa (an antidepressant medication) 10 milligrams (mg) once daily. Review of R31's active orders revealed an order with a start date and time of 8/12/2024 at 7:00 pm to monitor for side effects and behaviors every shift. Further review revealed the order for side effect monitoring was entered on 8/12/2024 at 4:50 pm. Review of the most recent Comprehensive Care Plan, initiated 5/20/2024 and last revised 6/28/2024, indicated a focus area for psychotropic drugs to manage anxiety and depression. The interventions included to, .administer medications as ordered. And observe for tolerance and effectiveness. Report any possible adverse side effects to MD/ARNP (Medical Doctor/Advanced Registered Nurse Practitioner). Review of R31's MAR for May 2024 revealed Celexa administration began on 5/18/2024. Further review revealed no evidence of monitoring for Celexa side effects or efficacy. Review of R31's MAR for June 2024 and July 2024 revealed no evidence of monitoring for Celexa side effects or efficacy. Review of R31's MAR for August 2024, revealed no evidence of monitoring for Celexa side effects or efficacy until 8/12/2024 during second shift. During an interview on 8/12/2024 at 4:45 pm the DON revealed antidepressants should be monitored and it should be in the orders and the MAR. The DON confirmed R31 was care planned for antidepressant monitoring. The DON reviewed R31's EMR orders and confirmed there was no order for Celexa side effect or efficacy monitoring and therefore not on the MAR. The DON also confirmed the Celexa order did not include a monitoring condition in the medication administration system. The DON stated she would correct the order to require side effect and efficacy documentation during medication administration.

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on staff interview and record review, the facility failed to document discharge needs and assessment of a resident being discharged home for one of three residents (R) R44 out of 22 sampled residents. The result of this failure was incomplete documentation and communication among staff in the discharge process of R44. Findings include: Review of R44's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R44 was admitted to the facility on [DATE] with the diagnosis of fracture of unspecified part of the right femur with subsequent encounter for closed fracture with routine healing. Review of R44's Admission Minimum Data Set (MDS), revealed R44 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This represented R44 was cognitively intact. Review of R44's Progress Notes revealed no documentation of the discharge needs or assessment of R44 when discharged home. There was also no date in the progress notes as to the date R44 was discharged home. Review of R44's Discharge Instructions provided by the facility was, dated 8/8/2024, which included information about the medical equipment name and home health company with phone numbers. There was no documentation of an assessment being completed prior to discharge from the facility for R44. R44's signature along with the date of 8/9/2024 was noted to be on this form. Interview on 8/14/2024 at 10:10 am, the Social Services Director (SSD) stated, I talked to the husband, and he said he might have something to use for a bedside commode. The SSD revealed she faxed the referral to the home health agency. When asked if she called the home health agency to see if they had received this referral, the SSD did not reply and there was no documentation to support there was conversations with the home health agency to reflect they acknowledged their receipt of this information. The SSD reviewed the EMR and confirmed there was no documentation of discharge planning other than the discharge instruction sheet that R44 signed on 8/9/2024. Interview on 8/14/2024 at 10:41 am, Licensed Practical Nurse (LPN) 1 confirmed there was no documentation of a discharge assessment of R44 in the progress notes when R44 was discharged on [DATE]. Interview on 8/14/2024 at 2:52 pm, the Director of Nursing (DON) stated, .d/c (discharge) note should state when the resident left, medications reviewed, follow up appointments, and summary of all home health and equipment referrals. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/14/2024 at 3:08 pm, the Administrator stated, I expect my staff to document when the resident was discharged and to where discharged , who did they go home with and how did they go. I expect that they also add in the note the medications that were gone over and if they understood. The administrator confirmed that a nurse that discharges a resident should document the condition of the resident at the time of discharge. The administrator also stated, They should put in their note if the resident or RP declined having the equipment that PT recommended when they go home.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on staff interview, record review, and review of the facility's policy titled, Charting and Documentation, the facility failed to document pressure ulcer dressing changes for one resident (R) R49 out of three. This failure resulted in a lack of documentation in the medical record and communication of all staff involved in the care of R49. Findings include: Review of the facility's policy titled, Charting and Documentation, dated 12/2023, revealed, .Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; f. notification of family, physician or other staff if indicated; and g. the signature and title of the individual documenting . Review of R49's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R49 was admitted to the facility on [DATE] with the diagnosis of an unstageable sacral pressure ulcer. Review of R49's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/16/2024 revealed R44 had a stage 3 pressure ulcer that was present on admission to the facility. Review of R49's Physician Orders revealed an order dated 8/9/2024 to Clean sacrum wound with wound cleanser, apply Collagen sheet (Purple Box) to wound bed and cover with dry dressing. Review of R49's Progress Notes, dated 6/2024 through 8/12/2024 revealed a progress note dated 8/3/2024, which stated, .Wound cleaned and bandaged per physician orders. No pain or discomfort noted. There was no further documentation noted in the progress notes to reflect wound care. Review of R49's Care Plan dated 6/7/2024, .Provide my treatments as ordered, observe response to treatment. If poor, no response, or deterioration notify MD/NP (medical doctor/nurse practitioner) . Interview on 8/12/2024 at 3:50 pm and at 5:30 pm, the Wound Nurse/Registered Nurse (WN/RN) confirmed a Skin and Wound Note is made in the progress notes each time a treatment is performed. The WN/RN also stated, I was told a couple of weeks ago to chart on the TAR (Treatment Administration Record) and then to make a note in the progress notes each time I did a dressing change. Sometimes I forget to do one and not the other. Interview on 8/12/2024 at 5:45 pm, the Director of Nursing (DON) stated, There is to be a progress note made each time a wound care dressing is done. The note should consist of the appearance of the wound, drainage, any foul odor, is the size increasing or decreasing, is the wound improving or getting worse since the last dressing change that was performed. When asked when she (DON) instructed the wound care nurse to make a progress note each time a dressing change was performed the DON replied, A couple of months ago.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28306 Based on staff interview, record review, review of the dialysis contract, and review of the facility's policy titled, End-Stage Renal Disease, Care of the Resident with, the facility failed to completely document care of a dialysis resident and failed to collaborate with the dialysis center for one of one resident (R) R9 out of 22 sampled residents. This failure resulted in a lack of documentation in the medical record and communication of all staff involved in the care of R9. Findings include: Review of the facility's policy End-Stage Renal Disease, Care of the Resident with dated 9/2010 revealed, Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care . Review of the dialysis contract dated 5/15/2024 stated, . Provider shall document all Dialysis Services, Related Services, (as defined below) and all other information that should be documented in accordance with standard Clinical documentation practices. At a minimum such documentation must include laboratory values, vital signs, medications administered or changed, the reason any medication or other service was not provided in accordance with physician's orders or the resident's plan of care and any change in the resident's medical status. Provider shall make available to Facility copies of all documentation at the time the resident is transported from Clinic back to Facility . Facility will make portions of the individual resident clinical record available to Provider, including the resident's plan of care, medication orders, contact information for the resident's responsible party and attending physician and other information necessary to ensure that the resident experiences a continuum of care while receiving Dialysis Services from Provider . Review of R9's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R9 was readmitted to the facility on [DATE] with the diagnoses of end stage renal disease and chronic kidney disease. Review of R9's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/24/2024 revealed R9 had a Brief Interview for Mental Status (BIMS) score of 15 out 15. This represented R9 was cognitively intact. This MDS also coded R9 as receiving dialysis. Review of R9's Care Plan revealed, (R9) has chronic end stage renal disease and will be getting hemo-dialysis 3 [sic] x (times) week. Interventions in place were administer my medications as ordered, go to dialysis 3 [sic] x week for her scheduled dialysis appointments, and observe me for complications of my disease process. Review of R9's Physician Orders revealed an order dated 5/15/2024 which stated, Obtain weights before and after dialysis. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's Dialysis Transfer Form, dated 7/01/2024 through 8/12/0224 revealed pre and post dialysis documentation were incomplete with areas on both sections left blank. There were also missing signatures of the nurse that documented these assessments along with missing dates and time these assessments occurred. Under the Middle Portion To Be Completed By Dialysis Unit And Returned With Resident there was incomplete documentation to reflect the care of the resident while receiving dialysis. This missing documentation was to be filled out by the dialysis center. Interview on 8/14/2024 at 10:41 am, Licensed Practical Nurse (LPN) 1 stated, You (nurse) have to fill out the vital signs and any changes in the resident fill this out, so the dialysis center knows about it. LPN1 confirmed there was missing documentation on the Dialysis Transfer Form that should have been filled out completely and not left blank. Interview on 8/14/2024 at 2:17 pm, the Director of Nursing (DON) confirmed all areas on the pre and post dialysis assessments are to be filled out by the nurse and not left blank. The DON stated, The nurse should review the dialysis center's documentation and if any areas are left blank, then they are to call them and fax the transfer form back to them so the nurses there can document the areas that had missing documentation on it.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 09262 Based on observation, interview, and review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers, the facility failed to ensure that the daily nurse staffing was posted to accurately reflect the actual staff hours to care for the 54 residents. This failure had the potential to inaccurately inform any resident, family member, or visitor of the available nursing staff caring for residents. The sample size was 22 residents. Findings include: Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers dated 10/2022 indicated, Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents .1. Within two hours of the beginning of each shift, the number of licensed nurses . and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location .3. Shift staff information shall be recorded .g. The actual time worked during that shift for each category and type of nursing staff . Observation on 8/11/2024 at 7:54 pm revealed the daily nurse staff document was behind glass doors on the bulletin board in the hallway across from the therapy room and indicated the date of 8/9/2024 and 52 residents. Interview on 8/12/2024 at 3:31 pm, the Administrator stated that the Director of Nursing (DON) was responsible for completing the form and posting it Monday through Friday, and the RN Supervisor was responsible for posting the document daily on weekends. Interview on 8/13/2024 at 9:02 am, the Administrator revealed that the daily nurse staffing document did not include the rehabilitation Certified Nurse Aide (CNA), the bath CNA and the multipurpose CNA. She revealed that the nursing schedule did not include the rehabilitation CNA, the bath CNA, and the multipurpose CNA either because she did not want the CNAs to think there were extra staff and call off.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 09262 Based on interview, review of facility documentation, and review of the facility's policy titled, Antibiotic Stewardship, the facility failed to develop an effective Antibiotic Stewardship Program (ASP) to monitor antibiotic use. Specifically, the facility failed to ensure that residents were not prescribed an antibiotic, or were not administered an antibiotic(s), without diagnostic testing that identified an organism and documented symptomology to support the continued use of an antibiotic. This deficient practice has the potential to affect all residents in the facility. Facility census was 54 residents. Findings include: Review of the facility's policy titled Antibiotic Stewardship dated 9/2022 indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program/QAPI (Quality Assurance and Performance Improvement) Committee .Antibiotic usage and outcome data will be collected, documented, and any trends will be reported to the QAPI committee. Review of the facility's ASP, since the last recertification survey on 8/18/2022, revealed that the Antibiotic Stewardship data documentation provided by the Infection Preventionist (IP)/Director of Nursing (DON) revealed that December 2023 was the first month of the ASP. Further review of the data collection provided by the IP/DON revealed that there was data collection for January 2024, none for February 2024, and data collection for March through July 2024. Review of the Infection Control Surveillance manual provided by the IP/DON on 8/14/2024 at 2:04 pm revealed the following ASP information: Review of the December 2023 Infection Control Surveillance document indicated 10 infections for the month, eight infections were Urinary Tract Infection (UTIs) of which seven developed in the facility. In addition, three of the 10 infections documented that the infection did not meet the McGreer's criteria. According to the surveillance document, R103 was prescribed Amoxicillin x (times) 10 days, R104 was prescribed Rocephin 1-gram x 2 doses, and R29 was prescribed Cefdinir. Review of the document attached to the December 2023 surveillance revealed there were no interventions for the three residents (R103, R104 and R29) that were prescribed an antibiotic even though their symptoms did not meet the McGreer criteria. Review of the January 2024 Infection Control Surveillance document indicated 11 infections of which six resident's symptoms (R49, R105, R8, R38, R20 and R106) did not meet McGreer's criteria. R49 complained of cough and was prescribed Amoxicillin x 2 days; R105 was pulling on ear and was prescribed Amoxicillin; R8 complained of cough on two separate times and was prescribed Azithromycin for the first cough episode and Doxycycline for the second cough episode; R38 complained of a cough and was prescribed Doxycycline; R20 complained of a cough and was prescribed Levaquin 500 milligram (mg) for 10 days; and R106 complained of vaginal itch and was prescribed Diflucan 150 mg for three doses. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the document attached to the January 2024 surveillance revealed there were no interventions for the seven residents who were prescribed antibiotics even though their symptoms did not meet McGreer's criteria. Review of March 2024 Infection Control Surveillance document indicated 10 infections of which eight infections were UTIs. Of the 10 infections, two infections (R39 and R17) infection did not meet McGreer's criteria. R39 complained of dysuria and was prescribed Rocephin 1 gram one dose and Macrobid for seven days. Review of March 2024 Monthly Infection Surveillance Report dated 2/1/2024 did not have any documentation of interventions for the one resident (R39) who was prescribed an antibiotic even though R39's symptoms did not meet the McGreer's criteria. Review of the April 2024 Infection Control Surveillance document revealed 13 total infections of which nine were UTIs. The report indicated that three residents (R39, R31 and R107) were placed on prophylactic antibiotics. R39 and R107's infections were documented that the infection did not meet the McGreer's criteria. R29, R108, R31 and R50 the document indicated their infection did not meet McGreer's criteria. R29 complaint of cough and was prescribed Augmentin for undocumented days; R108 complained of cough and was prescribed Augmentin for undocumented days; R31 had a catheter and was prescribed Cipro for undocumented number of days; and R50 was admitted with a wound and the column for antibiotic was blank. Interview on 8/14/2024 at 2:16 pm, the IP/DON confirmed that March and April had so many UTIs, and that there were many residents whose symptoms did not meet McGreer's criteria. The IP/DON stated that if a resident is on hospice, the hospice nurse contacts the hospice physician to get an antibiotic order without any testing. The IP/DON stated that she had no evidence to show that residents' who infections did not require an antibiotic was addressed. Review of May 2024 Infection Control Surveillance document indicated 12 total infections of which six were UTIs, two were Clostridioides difficile (C-Diff), one respiratory and three were wound infections. Of the 12 infections, six infections (R109, R8, R106, R17, R32, and R1) did not meet McGreer's criteria. R109 was hospice with no indication of what type of infection and the symptoms. The antibiotic section was left blank. R8 had wound drainage, and a culture was obtained. There was no documentation of the culture results and the column for antibiotic was left blank. R106 complained of a cough and the antibiotic column was left blank. R17 and R32 had a UTI was given Rocephin 1 gram one does even though the urinalysis showed no growth. R1 had wound drainage, and the culture showed less than 10,000 organisms. R1 was placed on Zosyn IV. There was no documentation attached to this report that indicated inservice or interventions implemented for the residents who were prescribed an antibiotic even though their symptoms did not meet McGreer's criteria. Review of the June 2024 Infection Control Surveillance report indicated eight total infections of which four were UTIs. Four of the eight infections (R4, R30, R10 and R24) were documented as not meeting the McGreer's criteria. R4 complained of cough and was prescribe a Z-pack [Zithromax (azithromycin)]; R30 complained of sore throat and was prescribed Amoxicillin; R10 had a UTI and was prescribed Levaquin and R24 had wound abscess, no culture was obtained because resident was on hospice and prescribed Keflex. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115667	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colquitt Regional Senior Care & Rehabilitation	101 Cobblestone Trace SE Moultrie, GA 31768

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the June 2024 Monthly Infection Surveillance Report dated 7/06/2024 indicated a total of five infection of which one was respiratory and four were UTIs. The attached document indicated Trends identified increased UTIs in April and May and Preventative/Control Measure Taken indicated, referred several residents with recurrent UTIs to urology for prophylactic treatment .inservice provided for all nursing staff on 6/17/2024. The IP/DON provided documentation for all nursing staff attending inservice education regarding hand hygiene and perineal care. The IP/DON stated that there was no documentation of interventions for residents listed with infections that did not meet McGreer's criteria. Review of the July 2024 Infection Control Surveillance report indicated eight infections of which four UTIs, one abscess, two wound and one C-Diff. One resident (R49) infection was marked as not meeting McGreer's criteria. R49 complained of UTI and was prescribed Macrobid for seven days. Interview with the IP/DON on 8/14/2024 at 2:16 pm, the IP/DON revealed that the McGreer's criteria (Which defines the resident's symptoms and other clinical criteria that are used to meet infection surveillance definitions. Infection surveillance definitions are essential for consistently monitoring infections over time and to determine where infection prevention efforts are needed. The revised McGreer criteria require more diagnostic information) was used by the facility to guide the ASP. Interview with the IP/DON on 8/14/2024 at 2:16 pm, the IP/DON confirmed that she did not have any ASP prior to 12/2023, and she confirmed that 2/2024 ASP data was missing. Interview on 8/14/2024 at 2:16 pm the IP/DON stated that she had no evidence of other interventions after analyzing the data other than June 2024 inservice when all nursing staff were trained on hand hygiene and perineal care. She stated that she had no explanation of infections on the surveillance documents that she indicated that the infection symptoms were marked N which meant the infection was not a true infection based on review of Mc Greers. She confirmed she had not done any interventions for the infections that did not meet the criteria.