STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interview, and facility policy review, the facility failed to evaluate a resident's physical and cognitive ability to safely self- administer medication for one (Resident (R) 27) of six residents during medication administration observations out of a total sample size of 21 residents. This failure resulted in the resident administering the incorrect amount of medication.Findings include:Review of the facility's policy titled, Self-Administration of Medications, dated May 2020, revealed, . 1. The facility and Interdisciplinary Care Team should assess and determine resident eligibility to self-administer medications by: a. Evaluating resident's functionality and health condition, b. Educate the resident to ensure the resident is able to state the name, dose, strength, frequency and purpose for use of his/her medications, c. Educate the resident to ensure he or she understands the possible side effects of medications and that he or she should notify the facility staff if any of these events are experienced, d. Educate the resident to correctly administer, inject or apply his or her medications . 3. Facility should ensure that the orders for self-administration of medications list the specific medication(s) that the resident may self-administer . 6. Facility should document in the resident's care plan whether the resident or the facility staff is responsible for the storage of the resident's medications . j. Facility staff should document the self-administration of medications and self-storage of medications in the resident's care plan.Review of R27's Clinical/Charting Snapshot located under the Charting section of the electronic medical record (EMR) revealed R27 was admitted to the facility on [DATE] with diagnoses including allergy, unspecified, and chronic obstructive pulmonary disease (COPD).Review of R27's undated Physician Orders located under the Charting section of the EMR, reflected an order written on 7/1/2025 for Flonase 0.05 [milligrams] mg [per] actuation spray one spray to each nostril via nasal inhalation twice daily for allergies. The orders did not indicate that R27 was able to self-administer the medication.Review of R27's Plan of Care, last reviewed 10/14/2025, under Care Plan located in the Charting section of the EMR, revealed no problem statement or interventions for the self-administration of medication(s).Review of a Self-Medication Report as of 12/4/2025 at 1:49 PM located under Reports under the Clinical Reporting section in the EMR revealed no Self-Medication Assessment for R27.During an observation on 12/2/2025 at 8:35 am, R27 self-administered two sprays of Flonase spray into each nostril. Registered Nurse (RN) 1 handed R27 the medication bottle to self-administer. R27 cleared her nostrils by gently blowing her nose. R27 shook the medication bottle, closed her left nostril with a finger, inserted the nozzle tip into the right nostril. R27 inhaled through her nose while pressing down on the nozzle to spray. R27 administered two sprays to the right nostril and repeated the process for the left nostril.During an interview on 12/2/2025 at 8:49 am, RN1 indicated R27 could self-administer the nasal spray; she [RN1] had to monitor R27 during medication administration. RN1 could not confirm if R27 was assessed for self-administration of medications and did not know how to verify.During an interview on 12/4/2025 at 2:10 pm, the Assistant Director of Nursing (ADON) stated residents were assessed for self-medication administration if the residents requested. The ADON indicated R27 was not assessed to self-administer the nasal spray. The ADON said that there was a form located under the assessments section in the EMR to complete when the resident was (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed. The ADON said after the resident was assessed, a physician's order must be obtained and then it was care planned. The ADON confirmed that R27 was not assessed for medication self-administration, there was not a physician's order, and it was not care planned.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, family member and staff interviews, record review, and facility policy review, the facility failed to ensure the call button to activate the emergency call light was accessible for two (Resident (R) 3 and 87) of 21 residents in the sample. This failure placed the residents at risk for accident, injury, or unmet needs related to an inability to call for staff assistance.Findings include:Review of the policy titled, Call Light System Policy and Procedure dated June 2024, revealed, Staff should verify the call light is within reach prior to leaving the resident alone in their room.1. Review of R3's Record of Admission, located in the Resident tab in the Snapshot of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including paraplegia, weakness, and vascular dementia. Review of R54's Care Plan, dated 7/1/2023 and found in the Resident tab under Care Plans in the EMR revealed, [R3] was at risk for fall [sic] or injury from fall related to impaired mobility. The interventions for this included, call light within reach, with prompt response to her requests.Review of R3's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/9/2025 and located in the Resident table of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated severe cognitive impairment. The MDS also indicated R3 had lower extremity impairment and was dependent on staff to complete toileting hygiene, bathing, dressing, personal hygiene, and transfers. During an observation on 12/1/2025 at 1:17 pm, R3's call button was observed hanging on the side rail, out of reach of the resident. During an observation on 12/3/2025 at 7:44 am, R3's call button was observed dangling through the right handrail out of reach of the resident. During an interview on 12/3/2025 at 10:15 am with Certified Nurse Aide (CNA) 1, she confirmed call buttons should always be within the resident's reach, adding it allows the residents to get a hold of the staff if they need anything. During an interview on 12/3/2025 at 10:55 am with the Wound Care Registered Nurse (WC), she confirmed R3's call button was not within her reach when WC entered R3's room to provide wound care. 2. Review of R87's Clinical/Charting Snapshot located under the Charting section of the EMR revealed R87 was admitted to the facility on [DATE] with diagnoses including cerebral palsy, unspecified; vascular dementia, mild; functional quadriplegia; and current pathological fracture, left humerus (upper arm).Review of R87's Plan of Care, initiated 1/13/2023 under Care Plan located in the Charting section of the EMR, revealed, [R87] requires assistance with activities of daily living [ADLs] . Reduced range of motion [ROM] to Left hand/fingers and shoulder . The interventions included: Place call light within reach. Another area, [R87] is at risk for falls . included an intervention: Instruct on use of call light and place within reach when in room.During an observation and interview on 12/1/2025 at 11:15 am, R87 was in bed, family member (FM) 1 at bedside. The button to activate the call light was hanging across the left handrail of the bed not within reach of R87. R87 demonstrated the inability to reach the call button to activate the call light. During an interview, FM1 indicated the call light button was often outside of R87's reach. During an observation and interview on 12/1/2025 at 11:28 am, Licensed Practical Nurse (LPN) 1 said that R87 had a fracture of the left shoulder, had functional limitations, and required the call button near the right hand to activate the call light. LPN1 observed the call button hanging across the left handrail of the bed and placed the call light on R87's chest near the right hand within reach.During observations on 12/3/2025 from 9:15 am to 10:04 am and at 10:23 am, R87 was lying asleep in bed. R87's call button was dangling over the left handrail near the floor, not within reach. During an interview on 12/4/2025 at 12:10 pm, the Director of Nursing (DON) stated the call light should be accessible to every resident. The DON said that it is the nurse's and nursing assistant's responsibility to ensure the call button is within reach during rounds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure written notices for bed holds and transfers were provided to residents and/or resident representatives and that the Ombudsman was notified when residents transferred to the hospital for four of 21 sampled residents (Resident (R)1, R7, R83, and R94) reviewed for hospitalization. These failures had the potential to cause confusion for residents and their representatives regarding the reason for their hospitalization, their ability to return to the facility, and their ability to appeal the discharge.Findings include:Review of the policy titled, Bed Hold and Returns, dated October 2024, revealed, Prior to transfers and therapeutic leaves, the residents or resident representative will be informed in writing of the bed-hold and return policy . Prior to a transfer, written information will be given to the resident and the resident representatives that explain in detail: a. The rights and limitations of the residents regarding bed-holds; b. the reserve bed payment policy as indicated by the state plan [Medicaid Residents]; c. The facility per diem rate required to hold a bed [non- Medicaid], or to hold a bed beyond the state bed-hold period [Medicaid residents]; and the details of the transfer.Review of the facility policy titled, Resident Transfer and Discharge Rights Policy and Procedure, revised September 2024, revealed, .3. The resident and/or representative [sponsor] will be notified in writing of the following information: a. The reason for the transfer or discharge; b. The effective date of the transfer or discharge; c. The location to which the resident is being transferred or discharged ; . 4. Office of the State Long-Term Care Ombudsman will be notified of the transfer/discharge. 1. Review of R1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/16/2025, located in the electronic medical record (EMR) under the Charting/MDS tab, revealed an admission date of 3/13/2023 with diagnoses which included pneumonia, Alzheimer's disease, and atrial fibrillation. A Brief Interview for Mental Status (BIMS) score of six out of 15, indicated R1 was severely cognitively impaired.Review of R1's Nurse Progress Note, dated 8/15/2025 and located in the EMR under the Charting/Progress Notes tab revealed, Resident has been laying in bed all morning. Resident states, I'm too weak to get out of bed. MD [Medical Doctor] gave order. Send resident down to ER [emergency room] for eval [evaluation] and treatment . All transport paperwork sent with resident.Review of R1's Nurse Progress Note, dated 8/18/2015, located in the EMR under the Charting/Progress Note tab, revealed, resident returned to facility around 1420 [2:20 pm] . Review of R1's Nursing Home Transfer and Discharge Notice, dated 8/15/2025, provided by the facility, revealed blank sections that included Location to which resident is transferred or discharged , Notice given to, and Current Ombudsman Contact Information.Review of R1's EMR revealed no bed hold notice or documentation that a bed hold notice was provided.During an interview on 12/2/2025 at 9:17 am, R1 was sitting in a wheelchair at her bedside. R1 stated her (family member) took care of her paperwork. R1 stated she was in the hospital recently.During an interview on 12/2/2025 at 9:55 am, the Director of Nursing (DON) was asked if R1's responsible party was provided with a written notice for the bed hold and transfer when R1 was sent to the hospital in August 2025. The DON provided the Nursing Home Transfer and Discharge Notice, dated 8/15/2025, stating that R1's family member was mailed a copy. The DON was asked why there was no date or note documenting that the transfer notice was mailed. The DON stated sometimes she uploads the transfer notice before the notice was dated and documented as to when the notice was mailed.During a follow up interview on 12/4/2025 at 9:14 am, the DON confirmed the transfer form did not include the transfer location, documentation that a written notice was provided, and that the ombudsman was notified. The DON stated the Business Office Manager (BOM) handled the bed hold notices and ombudsman notifications.During an interview on 12/4/2025 at 9:20 am, the BOM was asked if R1's responsible party was provided with a written bed hold notice for R1's transfer to the hospital in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	August 2025 and if the ombudsman was notified of the transfer. The BOM stated R1 was an automatic bed hold as she was Medicaid. The BOM stated she was not sure what would happen if residents exceeded their allotted bed hold days. The BOM stated the Social Service Director (SSD) notified the ombudsman but that she would look into it since the SSD was on vacation.During a follow up interview on 12/4/2025 at 10:04 am, the BOM confirmed no bed hold notice was provided to R1's responsible party. The BOM provided a blank Nursing Home Bed Hold form for Medicaid residents, and confirmed the form did not include the daily per diem bed hold rate. The BOM confirmed she was unable to find documentation that the ombudsman was notified of R1's 08/15/2025 transfer to the hospital.2. Review of R7's Record of Admission, located in the Resident tab in the Snapshot of the EMR, revealed she was admitted to the facility on [DATE].Review of a Physician Order, dated 11/20/2025 and located under the Resident tab under Physician Orders in the EMR, revealed, send to ER for evaluation of left hip and leg following ground level fall.Review of a Nursing Home Transfer and Discharge Notice, dated 11/10/2025 and located in the Residents tab and in the Connections tab, revealed R7 was sent to the emergency department on 11/10/2025. In the area Notice given to: there was no date for Local long-term care Ombudsman Review. A review of R7's EMR revealed no bed hold notice for the hospital transfer on 11/10/2025.During an interview on 12/4/2025 at 10:00 am, the BOM revealed the SSD called the family and the Ombudsman the day after a resident discharged to the hospital; however, the SSD did not document this anywhere. The BOM confirmed there was no way to know if the Ombudsman was notified of the resident's transfer. The BOM also confirmed there was no bed hold notice for R7's 11/10/2025 transfer. 3. Review of R83's Clinical/Charting Snapshot under the Resident tab of the EMR indicated he was initially admitted to the facility on [DATE] with diagnoses that included bipolar disorder, chronic kidney disease, and functional quadriplegia.Review of R83's discharge MDS with an ARD of 10/8/2025, located in the EMR under the Charting/MDS tab, indicated the resident was discharged to the hospital.Review of R83's Notice of Transfer or Discharge, dated 10/8/2025 and found in the EMR's Documents tab, revealed no information regarding bed hold or indication that the facility provided a written bed hold notice to the resident or resident representative.4. Review of R94's Clinical/Charting Snapshot under the Resident tab of the EMR indicated he was initially admitted to the facility on [DATE] with diagnoses that included stage three kidney disease and diabetes.Review of R94's discharge MDS with an ARD of 9/15/2025, located in the EMR under the Charting/MDS tab, indicated the resident was discharged to the hospital.Review of R94's Notice of Transfer or Discharge, dated 9/15/2025 and found in the EMR's Documents tab, revealed no information regarding a bed hold or indication that the facility provided a written bed hold notice to the resident or resident representative.During an interview on 12/3/2025 at 1:45 pm, the Administrator stated that he was aware the bed hold notifications were not being provided to the residents or the residents' representatives.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - 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** Based on observations, staff interviews, record review, and facility policy review, the facility failed to develop and implement a comprehensive care plan directing interventions for positioning and feeding for two (Resident (R) 3 and R57) of a total sample of 21 residents. This failure placed the residents at risk for unmet care needs.Findings include:Review of the policy titled, Care Plan Meetings, dated September 2024, revealed Each resident will have an individualized plan of care in place . The Comprehensive Care Plan will be resident centered having the individual resident as the locus of control. The Comprehensive Care Plan will be resident centered having individual resident as a unitary being.1. Review of R3's Record of Admission, located in the Resident tab in the Snapshot of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with paraplegia, weakness, and vascular dementia. Review of R54's Care Plan, dated 8/23/2023 and found in the Resident tab under Care Plans in the EMR revealed, Actual pressure ulcers and [R3] is at risk for complication of infection or worsening and is at risk for new pressure ulcers due to [R3] prefers lying on her back and has been resistive to turning and repositioning at times. An intervention was wedge while in bed, positioning with pillow . Review of R3's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/9/2025 and located in the Resident tab under MDS of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated severe cognitive impairment. The MDS indicated R3 had lower extremity impairment and was dependent on staff to complete toileting hygiene, bathing, dressing, personal hygiene, and transfers. The MDS also indicated R3 had one unhealed stage four pressure injury and had a pressure reducing device for her chair and bed.During an observation on 12/1/2025 at 1:17 PM, R3 was observed lying on her back without pillows or a wedge to offload the coccyx area. During a wound care observation on 12/3/2025 at 7:44 am, R3 was observed lying on her back without a pillow or wedge to offload the coccyx area prior to the start of treatment.During an interview on 12/3/2025 at 11:58 am, Licensed Practical Nurse (LPN) 3 confirmed that a wedge was not in use during R3's wound care and that there was no wedge in the room. LPN3 stated if the coccyx was not offloaded the wound could worsen.During an interview on 12/3/2025 at 10:55 am, the Wound Care Registered Nurse (WC) confirmed R3 did not have a wedge or pillows to offload the coccyx area when she entered the resident's room to provide wound care with LPN3. During an interview on 12/4/2025 at 12:08 pm, the Director or Nursing (DON) stated if a resident refused care or to allow the staff to implement interventions, it should be in the care plan. She added the care plan guides staff on how to care for the residents.2. Review of R57's quarterly MDS with an ARD of 10/7/2025, located in the EMR under the Charting/MDS tab, revealed an admission date of 6/25/2025 and diagnoses which included cerebral palsy, dysphagia (difficulty swallowing), and gastro esophageal reflux disease (GERD - stomach acid flows into the esophagus causing heartburn). R57 was dependent on staff for eating, received a mechanically altered diet, and was severely cognitively impaired.Review of R57's diet order, dated 7/1/2025, located in the EMR under the Charting/Physician Order tab revealed, Puree and Nectar thick liquids *No caffeine [Soda, Tea, or Coffee], no straws, coated spoon, no metal utensils, hard cup for fluids, milk, water, orange juice, or apple juice, and no bread.Review of R57's SLP [Speech-Language Pathologist] Evaluation and Plan of Treatment, dated 10/3/2025 and provided by the facility, revealed, . [Patient] often hyperextends his head/neck during meal consumption and requires tactile stim [stimulation]/hold to the posterior of his head to bring him forward and to assist him in maintaining a forward stance to decrease risk for aspiration. Review of R57's Care Plan, dated 11/19/2025, located in the EMR under the Charting/Care Plan tab revealed, Nutrition: Risk for altered nutritional status due to dx [diagnoses] of Cerebral palsy, anemia, needs altered diet . Dependent on staff for meals. Interventions included: Provide set up and feed meals, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Monitor tolerance to diet texture and ability to swallow during meals, and Allow extra time to eat as needed. The care plan did not include staff standing and holding the back of R57's head while feeding him.Review of R57's undated Kardex (computerized system of communication), located in the EMR under the Charting/Kardex tab, revealed nothing about standing or holding the back of R57's head while feeding him.On 12/1/2025 at 12:59 pm, R57 was observed sitting in his specialized wheelchair in the dining room for lunch. Certified Nurse Aide (CNA) 5 was noted to be feeding R57 a pureed diet. While spoon feeding R57, CNA5 stood next to R57, holding the back of his head. R57 ate 100 percent.During an interview on 12/4/2025 at 9:55 am, Physical Therapist Assistant (PTA) stated the speech therapist was involved with R57 and evaluated him on 10/3/2025, and a pureed diet with thickened liquids was recommended due to swallowing issues. PTA was asked if it was safe for a CNA to stand while feeding R57 in his wheelchair, and PTA stated, No because R57 could choke. PTA stated the speech therapist was unavailable to interview.During an interview on 12/4/2025 at 12:28 pm, the DON was asked about her expectations of CNAs feeding R57. The DON stated, safety first, but [R57] is hard to feed while sitting down because [R57] bites down on the spoon. The DON stated normally staff sit, but if staff do stand, R57 should be evaluated by speech therapy, and it should be care planned to stand if that is their recommendation. During an interview on 12/4/2025 at 3:03 pm, CNA5 stated the Speech Therapist told her to stand while feeding R57 and hold the back of his head because R57 throws his head back. CNA5 stated she tried sitting to feed R57, but R57 bites the spoon. CNA5 stated she was not sure if it was on the Kardex, but the speech therapist's instructions should be on the Kardex.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to ensure clinical criteria were met prior to prescribing and administering an antibiotic for a urinary tract infection (UTI) for two (Resident (R) 5 and R34) of six residents reviewed for unnecessary medications. This failure had the potential to cause antibiotic resistance, increased risk of Clostridioides difficile (C. diff) infection, and adverse drug reactions.Findings include:Review of the facility policy titled, Surveillance for Infections, dated September 2017, revealed, . 2. The criteria for such infections are based on the current standard definitions of infections, . 5. Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible, e. Bacteriuria WITH corresponding signs and symptoms of UTI; and f. Other positive cultures, and McGeer Criteria for UTI [Without indwelling urinary catheter] UTI should be diagnosed when there are localizing genitourinary signs and symptoms and a positive urine culture result. 1. Review of R5's comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/19/2025, located in the electronic medical record (EMR) under the Charting/MDS tab, revealed an admission date of 5/22/2025. R5 had a Brief Interview for Mental Status BIMS score of 15 out of 15, indicating R5 was cognitively intact. R5 took an antibiotic and had a diagnosis of urinary tract infection in the past 30 days.Review of R5's Nurses Progress Note, dated 10/10/2025, located in the EMR under the Charting/Progress Note tab, revealed, Resident very confused this shift, such as not being sure where she is. Resident voicing discomfort upon urination of pain and pressure. Resident has HX [history] of frequent UTIs with common symptoms of discomfort and the increase of confusion. Medical Doctor [MD] 2 called and gives new order to obtain Cath [catheter] U/A [urinary analysis] with reflex C&S [culture and sensitivity] . Review of R5's October 2025 Medication Administration Record (MAR), located in the EMR under the Charting/Physician Orders, revealed, 10/12/2025 Macrobid 100 mg [milligram] capsule . give 1 by mouth twice daily for 10 days for UTI, stop date:10/13/2025.Review of R5's Urine Culture, completed date 10/13/2025, located in the EMR under the Connections/Resident Results tab, revealed R5 was resistant to seven out of the 17 antibiotics. The results revealed a resistance to Macrobid. Review of R5's October 2025 MAR, located in the EMR under the Charting/Physician Orders tab, revealed 10/13/2025 cefuroxime axetil 500 mg tablet . 500 mg by mouth twice daily for UTI, stop date: 10/19/25. Review of R5's MD [physician] Progress Note, dated 10/21/2025 and located in the EMR under the Charting/Progress Notes tab revealed, Follow up of altered mental status, unspecified. Last visit, nurse [name] called reporting increased confusion. UA was ordered. UA showed proteinuria, hematuria. Cx [culture] ABN [abnormal]. Patient was on Macrobid to which there is resistance. Order was given 10/13 to replace Macrobid with cefuroxime 500mg po [oral] bid [twice daily] x [times] 5 d [days]. Pt [patient] is confused at today's visit.Review of R5's Urine Culture, ordered 10/24/2025 as a follow-up to antibiotic completion, located in the EMR under the Connections/Resident Results tab, revealed growth greater than 100,000 of [bacteria name]. No symptoms of a UTI were documented in the EMR.Review of R5's October 2025 and November 2025 MAR, located in the EMR under the Charting/Physician Orders tab, revealed 10/27/2025 Macrobid 100 mg capsule . 1 capsule by mouth twice daily for Urinary Tract Infection, discontinued 11/6/2025. The MAR indicated R5 was administered all doses although R5 showed resistance to Macrobid in the 10/13/2025 urine culture.Review of R5's Communication note, dated 11/25/2025 at 2:51 am, located in the EMR under the Charting/Progress Notes tab revealed, Patient has had increased confusion this HS [bedtime]. She thought she was in Florida and phoned her [family member] to tell her. I spoke with her [family member] over the phone, and she was concerned she was getting another UTI. She stated that [R5] always becomes disoriented when she has one. UTI STAT [the facility's protocol to encourage/push (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fluids] will start in the AM [morning]. Work sheet for UTI STAT (right away) filled out and placed on clipboard. Left message with unit manager about [family member] wanting UA [urinary analysis] done.Review of R5's Nurses Progress note, dated 11/25/2025 at 9:58 am, located in the EMR under the Charting/Progress Note tab revealed, [MD2] into facility this morning, due to resident increased confusion and HX of frequent UTIs, new order given to obtain cath U/A with C&SReview of R5's urine culture results, completion date 11/28/2025, located in the EMR under the Connections/Resident Results tab revealed > [greater than] 100,000 cfu/ml [colony-forming units per milliliter]-[bacteria name]. R5 was resistant to seven of the 17 antibiotics with an additional antibiotic showed intermediate.Review of R5's Order, dated 11/28/2025, located in the EMR under the Charting/Physician Orders tab, revealed, cefuroxime axetil 500 mg tablet . by mouth twice daily for Urinary Tract Infection, stop date 12/5/2025.Review of R5's Weekly Summary, dated 12/1/2025, located in the EMR under the Charting/Progress Notes tab revealed 11/25 Patient had an episode of delirium, so UTI STAT was initiated. MD visited and gave N.O [new order] for UA with C&S, refer to neurologist for delirium .11/28 Cefuroxime 500mg po BID for 7 days . UTI- UA grew out Providencia. Patient is alert and oriented with some confusion at times. She is pleasant and cooperative with care. Review of R5's Care Plan, dated 12/2/2025, located in the EMR under the Charting/Care Plans tab revealed UTI- Resident has an infection. An intervention included Urine: monitor color, odor, c/o [complaint of] urgency, Frequency or burning.Review of R5's Point of Care for toileting, dated 11/3/2025 to 12/3/2025 located in the EMR under the Charting/Point of Care tab revealed R5 was provided incontinent care two to three times daily. No pattern of increased incontinence frequency was found.On 12/2/2025 at 2:43 pm, R5 was awake in bed dressed in a gown and groomed. R5 stated she was on an antibiotic due to a UTI. R5 stated she didn't experience burning or other symptoms. R5 went on to say, Just the test showed a UTI. The doctor ordered the test. R5 stated she did not ask for the UA.During an interview on 12/2/2025 at 4:20 pm, the Infection Preventionist (IP) stated they used McGeer [evidence-based guidelines] for determining UTIs. The physician ordered the most recent UA for R5 due to R5 having increased confusion, which was documented in the progress notes. During an interview on 12/3/2025 at 1:57 pm, the IP stated R5's UTI met McGeer's criteria because of R5's confusion and the bacterial growth greater than 100,000. The IP reviewed a form with McGeer's criteria and reviewed R5's EMR for symptoms. The IP stated because the laboratory results were greater than 100,000, and R5 was having increased incontinence, this met criteria. When the IP was asked what she meant by increased incontinence, the IP stated the Certified Nurse Aide (CNA) reported that right after she provided R5 with incontinent care, the CNA turned to the roommate to provide her with incontinent care. At that time R5 informed the CNA she was urinating again. On 12/3/2025 at 2:13 pm, R5 stated the nurse used a needle (catheter) to collect urine for the UA, and it was unpleasant. R5 stated she had no symptoms and was not sure why a test was done. R5 stated she was just on an antibiotic recently for a UTI.During a follow up interview on 12/4/2025 at 10:50 am, the IP provided the McGeer Criteria for Infection Surveillance Checklist, from a facility binder. It included handwritten notes increased confusion 11/24-11/25- UA ordered and 11/25/2025 recurrence of psychosis [the change symbol] Thanksgiving x 2 freq [frequency] per CNA while still in room /c [with] other resident care. The IP was asked if 11/25/2025 was the only day R5 had increased incontinence. The IP stated, yes. The checklist was marked new or marked increase in incontinence, suprapubic pain, and a handwritten note > [greater] + [plus] Providencia + gram - [negative] rods. The IP confirmed these symptoms were not documented in the progress notes or in the CNA charting but should have been. The IP stated she has told the physicians about antibiotic stewardship, but the physicians still prescribe antibiotics. The IP confirmed she did not document her educational discussions with the physicians.During an interview on 12/4/2025 at 12:35 PM, the Director of Nursing (DON) stated, An altered mental status was not a good reason for a UA. The DON stated one day of increased incontinence did not meet the criteria for a marked increase in incontinence/frequency. The DON stated that physician education on the antibiotic stewardship (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	program should be documented.During a telephone interview on 12/4/2025 at 2:15 pm, MD2 stated he saw R5, and she was experiencing psychotic behavior that could be due to a UTI. MD2 stated he prescribed antibiotics due to R5's behavioral change and the culture. MD2 stated he prescribed antibiotics only when indicated. MD2 stated R5's incontinence was getting worse. MD2 was asked if the facility informed him the increased incontinence was just once. MD2 did not respond about the incontinence but stated that R5 had three cultures, all with growth, in October 2025 and was also seen by the gynecologist for a mass that she refused treatment for which might be contributing to the UTIs.2. Review of R34's quarterly MDS with an ARD of 10/16/2025, located in the EMR under the Charting/MDS tab, revealed an admission date of 2/2/2023. R34 had a BIMS score of 15 out of 15, indicating R34's cognition was intact. R34 took an antibiotic and had diagnoses of heart failure, chronic kidney disease, and Alzheimer's disease.Review of R34's EMR revealed R34 received an antibiotic at least monthly from December 2024 to November 2025 for UTI and UTI prophylaxis, for sinusitis, or for dental procedures.Review of R34's Antibiotic Therapy note, dated 12/3/2024, located in the EMR under the Charting/Progress Notes tab, revealed, Resident on Macrodantin [antibiotic] r/t [related to] prophylactic abt [antibiotic] for hx of UTI. No adverse s/s [signs/symptoms] noted or reported.Review of R34's Weekly Summary note, dated 1/3/2025, located in the EMR under the Charting/Progress Notes tab, revealed, Conts [continues] on PO ABT A/O [alert/oriented] x3 with some periods of confusion . continuously for proph. [prophylatic] measures to prevent UTI. No adverse reactions noted.Review of R34's Weekly Summary note, dated 1/12/2025, located in the EMR under the Charting/Progress Notes tab, revealed, on 1/04, resident's pending urine culture finalized which resulted proteus mirabilis. md notified and gave orders to d/c [discontinue] macrobid due to resistance and start bactrim ds [double strength].Review of R34's Nurses Progress Note, dated 2/17/2025, located in the EMR under the Charting/Progress Note tab revealed, Resident is not her baseline. Resident had c/o [complained] of numbness to right great toe. MD made aware. MD gave order to obtain UA With C&S .Review of R34's Antibiotic Therapy note, dated 2/18/2025, located in the EMR under the Charting/Progress Notes tab, revealed, Patient is currently on [oral antibiotic] for a UTI. Urine showed 2+ bacteria. Patient has been more confused this [bedtime]. She thinks she has to get up to go to work, and she gets confused if it's day or night time. [Oral] fluids have been encouraged. No adverse reactions noted to [antibiotic] therapy.Review of R34's Antibiotic Therapy note, dated 3/4/2025, located in the EMR under the Charting/Progress Notes tab, revealed, Resident on [oral] antibiotic Cipro r/t UTI until 3/9. No adverse s/s noted or reported. No c/o dysuria.Review of R34's EMR revealed no documentation of symptoms, other than confusion.Review of R34's Antibiotic Therapy note, dated 10/1/2025, located in the EMR under the Charting/Progress Notes tab revealed, resident continues on [oral antibiotic] for prophylactic use, no adverse reactions noted, po fluids [increased], resident at nurses station countless times asking for her pain med, resident walking and roaming in room out in hallway or to activities room . Review of R34's Order, dated 10/1/2025, located in the EMR under the Charting/Physician Orders tab revealed Macrodantin 50 mg capsule . *** to be given daily until further notice as prophylactic therapy*** 1 capsule by mouth every day for prophylactic therapy.Review of the EMR revealed no documentation regarding why the prophylactic antibiotic was ordered such as failed treatments or negative outcomes.Review of R34's Care Plan, dated 10/29/2025, located in the EMR under the Charting/Care Plan tab revealed Resident at risk for recurrent UTI's. An intervention included Urine: monitor color, odor, c/o urgency, Frequency or burning.On 12/1/2025 at 1:20 pm, R34 was sitting in a chair in her room dressed and groomed. R34 mentioned a nurse came into her room last night to give her an antibiotic for a UTI but she feels fine.During an interview on 12/3/2025 at 10:55 am, the IP was asked about R34's prophylactic antibiotic and her history of receiving antibiotics for one year. The IP stated she had informed the physician that the prophylactic antibiotic was against McGeer's criteria, but the physician still insisted on prescribing it. The IP stated the physician said R34 was at risk for sepsis due to her frequent UTIs. The IP stated R34's family member also wanted R34 on the antibiotic for prevention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The IP stated she was unsure where documentation was regarding her education of the physicians. During a telephone interview on 12/4/2025 at 2:06 pm, MD1 stated R34's prophylactic antibiotic was very appropriate due to various treatments that had been tried and her frequency of UTIs. MD1 stated he was aware of the facility's antibiotic stewardship program and that he used the lowest dose with the narrowest possible spectrum antibiotic. During a follow-up interview on 12/4/2025 at 2:55 pm, the IP provided a letter from MD1, with a facsimile time stamp of 12/4/2024 at 2:47 pm, that revealed, R34 is a patient under my care at [name of clinic]. R34 was seen on 11/12/2025. Patient suffers from chronic urinary infections that necessitate continued prophylactic treatment. She has failed conservative measures and as a way to maintain her comfort and avoid recurrent serious urinary bacterial infections it is prudent to continue low dose prophylactic antimicrobial therapy. Please feel to contact our clinic if you have any questions or concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, record review, facility policy review, and document review, the facility failed to ensure a medication error rate of less than five percent during observation of medication administration. The facility had three errors in 47 opportunities, which resulted in a six percent error rate. This affected three (Resident (R) 27, R42, and R87) out of six residents observed. Medication errors have the potential to result in adverse health outcomes.Findings include:Review of the facility's policy titled, Storage of Medication, dated May 2020, revealed, . III. Expiration Dating . 3. Certain medications or package types, such as . multiple dose injectable vials . require an expiration date shorter than the manufacturer's expiration date once opened to ensure medication purity and potency . 5. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse shall place a 'date opened' sticker on the medication and record the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days from opening, unless the manufacturer recommends another date or regulations/guidelines require different dating . 6. The nurse will check the expiration date of each medication before administering it . 8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining . Review of the American Diabetes Association's Safe Storage of Insulin, dated 2018 and located at: https://diabetes.org/sites/default/files/2023-10/ddrc-storing-insulin-2018.pdf, revealed insulin products contained in vials supplied by the manufacturers (opened or unopened) may be left unrefrigerated for up to 28 days and continue to work.1. Review of R27's undated Physician Orders located under the Charting section of the electronic medical record (EMR), reflected an order written on 7/01/2025 for Flonase 0.05 [milligrams] mg [per] actuation spray, one spray to each nostril via nasal inhalation twice daily for allergies. The order did not indicate that R27 was able to self-administer the medication.During a medication observation on 12/2/2025 at 8:35 am, R27 self-administered two sprays of Flonase spray, an allergy relief nasal spray, into each nostril. Registered Nurse (RN) 1 handed R27 the medication bottle to self-administer, and R27 administered two sprays to the right nostril and repeated the process for the left nostril. During an interview on 12/2/2025 at 8:49 AM, RN1 indicated R27 could self-administer the nasal spray; she [RN1] had to monitor R27 during medication administration. 2. Review of R42's Physician Orders located under the Charting section of the EMR, reflected an order written on 8/18/2502 for Vitamin B12 1000 micrograms (mcg) tablet one tablet sublingually (placed beneath the tongue to dissolve and be absorbed directly into the bloodstream) every day for Vitamin B12 deficiency.During an observation and interview on 12/1/2025 at 11:28 am, Licensed Practical nurse (LPN) 4 prepared medications for R42. LPN4 removed an over-the-counter stock bottle of vitamin B12 1000 mcg tablets from a drawer of the medication cart. LPN4 placed one tablet into a medication cup with the remaining medications. LPN4 administered the medications to R42 by mouth. R42 swallowed the medications whole with water. During an interview, LPN4 said that she did not realize the tablet should be administered under the tongue. LPN4 said that it was her responsibility to ensure that she read and understood the physician orders for medication administration.3. During an observation on 12/1/2025 at 11:28 am, LPN1 was observed drawing a sliding scale insulin (SSI) dose from a vial for R87. LPN1 removed a box of insulin aspart, a rapid-acting insulin, from the top drawer of the medication cart. The box had a handwritten open date of 10/30/25 and end date 11/28/2025. The insulin vial was not dated. LPN1 pulled the plunger back to draw eight units of insulin into a syringe for administration to R87. LPN1 administered the insulin to R87's abdomen, right upper quadrant. During an interview on 12/1/2025 at 11:46 am, LPN1 said that she misread the open and expiration date(s) on the box and thought the open date was 11/30/2025. LPN1 said that the insulin was recently opened. She did not know why there was not a date on the bottle, but it was on the box. LPN1 said that the risk of administering insulin after 28 days was that it would not be as effective.During an interview on 12/4/2025 at 12:10 pm, the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115701	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chatuge Regional Nursing Home	386 Belaire Drive Hiawassee, GA 30546

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON) stated nurses should follow the five medication rights when administering medications to ensure that the right medications were administered to the right person, the right dose, the right route, at the right time. The DON said that the nurses were responsible for checking expiration dates on all medication packaging before administration.