

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER STEWART COMMUNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 15TH STREET COLUMBUS, GA 31901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
	<p>A review of the file for Staff D, hired date 7-29-20, showed no current certification in emergency first aid.</p> <p>A review of the file for Staff E, hired date 6-18-24, showed no current certification in emergency first aid.</p> <p>A review of the staff schedule for October 2025 showed Staff C, Staff D, and Staff E listed.</p> <p>During an interview on 10/7/25 at 2:51 p.m., Staff B stated Staff C, Staff D, and Staff E were current direct care employees and were not licensed healthcare professionals. Staff B stated he/she was aware the employees did not have current emergency first aid certification.</p> <p>{0904} 111-8-62-.09(2)(b) Workforce Qualifications and Training. SS= D Such [work-related] training must include, at a minimum, the following: ... (b) Evidence of current certification in cardiopulmonary resuscitation where the training course required return demonstration of competency.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER STEWART COMMUNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 15TH STREET COLUMBUS, GA 31901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
	<p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interviews, the facility failed to ensure that any person working in the facility had evidence of current certification in cardiopulmonary resuscitation where the training course required return demonstration of competency for 3 of 4 sampled staff (Staff C, Staff D, and Staff E).</p> <p>Findings include:</p> <p>A review of the file for Staff C, hired date 6-28-13, showed no current certification in cardiopulmonary resuscitation.</p> <p>A review of the file for Staff D, hired date 7-29-20, showed no current certification in cardiopulmonary resuscitation.</p> <p>A review of the file for Staff E, hired date 6-18-24, showed no current certification in cardiopulmonary resuscitation.</p> <p>A review of the staff schedule for October 2025 showed Staff C, Staff D, and</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER STEWART COMMUNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 15TH STREET COLUMBUS, GA 31901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
<p>{0912}</p> <p>SS= D</p>	<p>Staff E listed.</p> <p>During an interview on 10/7/25 at 2:51 p.m., Staff B stated Staff C, Staff D, and Staff E were current direct care employees. Staff B stated he/she was aware the employees did not have current cardiopulmonary resuscitation certification.</p> <p>111-8-62-.09(5) Workforce Qualifications and Training.</p> <p>All direct care staff, including the administrator or on-site manager must have at least sixteen (16) hours of training per year.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure that all direct care staff, including the administrator or on-site manager, must have at least sixteen (16) hours of training per year for 2 of 4 sampled staff (Staff C and Staff D).</p> <p>Findings include:</p> <p>A review of the file for Staff C, hired date 6-28-13, showed no documentation of 16 hours of training.</p> <p>A review of the file for Staff D, hired date 7-29-20, showed no documentation of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER STEWART COMMUNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 15TH STREET COLUMBUS, GA 31901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
<p>{1508}</p> <p>SS= D</p>	<p>16 hours of training.</p> <p>During an interview on 10/7/25 at 2:51 p.m., Staff B stated he/she was unaware of the 16 hours of training per year requirement.</p> <p>111-8-62-.15(3) Admission.</p> <p>The administrator or on-site manager of a home must conduct an interview with the applicant and/or representative or legal surrogate, if any, of the applicant to ascertain that the home can meet the applicant's needs. The administrator or on-site manager must obtain a report of physical examination conducted by a by a licensed physician, nurse practitioner or physician's assistant dated within 30 days prior to the date of admission using the specific report of physical examination form made available by the Department on its website to assess whether the home can meet the applicant's needs. Where a home admits a resident without the required physical examination pursuant to a specific request for an emergency placement made by a governmental agency responsible for adult protective service, local law enforcement or a case manager, the home must retain documentation of the need for the emergency placement and obtain a copy of a physical examination within 14 days following the emergency admission. The required report of physical examination form must be completed in its entirety.</p> <p>Authority: O.C.G.A. §§ 31-2-7, 31-7-1, 31-7-2.1 and 31-7-12.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, the facility failed to obtain a report of physical examination conducted by a by a licensed physician, nurse practitioner or physician's assistant dated within 30 days prior to the date of admission using the specific report of physical examination form made available by the Department on its website to assess whether the home can meet the applicant's needs for 1 of 5 sampled residents (Resident #1).</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER STEWART COMMUNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 15TH STREET COLUMBUS, GA 31901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
	<p>Findings include:</p> <p>A review of the file for Resident #1, admission date 10/24/24, revealed no Physician's Medical Evaluation form available.</p> <p>During an interview on 10/7/25 at 2:51 p.m., Staff B stated Resident #1 did not have a Physician's Medical Evaluation form available for review due to the resident being homeless prior to admission.</p> <p>{1709} 111-8-62-.17(9) Written Care Plan. SS= D Written Care Plan. Utilizing the information acquired during the admission process and the move-in adjustment period, a home which provides proxy caregivers or memory care must develop the resident's individual written care plan within 14 days of admission and require staff to use the care plan as a guide for the delivery of care and services to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to develop the resident's individual written care plan within 14 days of admission and require staff to use the care plan as a guide for the delivery of care and services to the resident for 4 of 4 sampled residents (Resident #1, Resident #2,</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER STEWART COMMUNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 15TH STREET COLUMBUS, GA 31901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
	<p>Resident #3, and Resident #4).</p> <p>Findings include:</p> <p>A review of the file for Resident #1, admission date 10/24/24 showed no written care plan available.</p> <p>A review of the file for Resident #2, admission date 2/23/22 showed no written care plan available.</p> <p>A review of the file for Resident #3, admission date 2/24/12 showed no written care plan available.</p> <p>A review of the file for Resident #4, admission date 7/31/24 showed no written care plan available.</p> <p>A review of the Medication Administration Record (MAR) for Resident #1, Resident #2, Resident #3, and Resident #4 for October 2025 showed staff initialed daily for medication administration.</p> <p>During an interview on 10/7/25 at 2:51 p.m. Staff A stated he/she was unaware of the written care plan requirement and that he/she did not know what it was.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER STEWART COMMUNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 15TH STREET COLUMBUS, GA 31901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
{P 0401} SS= D	<p>111-8-100-.04(2) Written Informed Consent.</p> <p>Written Informed Consent. No licensed facility will permit a proxy caregiver to provide health maintenance activities by or through the licensed facility unless the individual with a disability, or the legally authorized representative has executed an informed consent. ...</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interviews, the facility failed to permit a proxy caregiver to provide health maintenance activities by or through the licensed facility unless the individual with a disability, or the legally authorized representative has executed an informed consent for 4 of 4 sampled residents (Resident #1, Resident #2, Resident #3, and Resident #4).</p> <p>Findings include:</p> <p>A review of the file for Resident #1, admission date 10/24/24 showed no informed consent for Proxy Care available.</p> <p>A review of the file for Resident #2, admission date 2/23/22 showed no informed consent for Proxy Care available.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106030151	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER STEWART COMMUNITY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1125 15TH STREET COLUMBUS, GA 31901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
	<p>A review of the file for Resident #3, admission date 2/24/12 showed no informed consent for Proxy Care available.</p> <p>A review of the file for Resident #4, admission date 7/31/24 showed no informed consent for Proxy Care available.</p> <p>A review of the Medication Administration Record (MAR) for Resident #1, Resident #2, Resident #3, and Resident #4 for October 2025 showed staff initialed daily for medication administration.</p> <p>During an interview on 10/7/25 at 2:51 p.m. Staff A stated each resident in the facility was administered medications by Proxy Care. Staff A stated he/she was unaware of the informed consent for Proxy Care requirement and that he/she did not know what it was.</p>		