STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115266	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archbold Living Camilla	37 South Ellis Street Camilla, GA 31730

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 - Some	Ensure medication error rates are not 5 percent or greater. (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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(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 - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the facilities' policy titled Administering Medications, Facility B failed to ensure that one of three nurses (Licensed Practical Nurse (LPN) FF) observed during medication administration observation did not pre-set medications in labeled cups for one hall of four halls (100-Hall) resulting in medication error rate of 55.56%.Findings includeReview of the facilities' policy titled Administering Medication dated 10/19/2017 under the Policy Statement revealed, Medications shall be administered in a safe and timely manner, and as prescribed. Under the section titled Policy Interpretation and Implementation revealed, 7. The individual administering the medication must verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.An observation on 8/8/2025 at 8:22 am, LPN FF was observed coming up the hall with her medication cart. On top of her medication were six plastic labeled cups with room numbers (108, 110, 111) and a letter (A or B) to indicate room and bed of the residents.1. Review of the physician orders for R13 in room [ROOM NUMBER]A revealed eight scheduled medications for the 8:00 am medication administration. Review of the Summary Report Meds/Tx All Shifts PPNH/(Name) revealed eight medications were administered as indicated by LPN FF initials.2. Review of the physician orders for R14 in room [ROOM NUMBER]B revealed four scheduled medications for the 8:00 am medication administration. Review of the Summary Report Meds/Tx All Shifts PPNH/(Name) revealed four medications were administered as indicated by LPN FF initials.3. Review of the physician orders for R10 in room [ROOM NUMBER]A revealed seven scheduled medications for the 8:00 am medication administration. Review of the Summary Report Meds/Tx All Shifts PPNH/(Name) revealed seven medications were administered as indicated by LPN FF initials.4. Review of the physician orders for R16 in room [ROOM NUMBER]B revealed three scheduled medications for the 8:00 am medication administration. Review of the Summary Report Meds/Tx All Shifts PPNH/(Name) revealed two medications were administered as indicated by LPN FF initials. There was no evidence of one medication (Atorvastatin) being administered as indicated as boxed out.5. Review of the physician orders for R6 in room [ROOM NUMBER]A revealed five scheduled medications for the 8:00 am medication administration. Review of the Summary Report Meds/Tx All Shifts PPNH/(Name) revealed five medications were administered as indicated by LPN FF initials.6. Review of the physician orders for R18 in room [ROOM NUMBER]B revealed eight scheduled medications for the 8:00 am medication administration. Review of the Summary Report Meds/Tx All Shifts PPNH/(Name) revealed eight medications were administered as indicated by LPN FF initials. During an interview on 9/10/2025 at 9:27 am, LPN FF confirmed that she had pre-set up her medication for each resident on her assignment. She initially gave a scenario of why her medications were labeled and sitting on the cart as she pushed the cart down the hall. She then stated that the day she decided to do something wrong, she got caught. She continued to state that she had been previously told by the Pharmacist consultant not to do this.During an interview on 9/10/2025 at 2:35 pm, the Director of Nursing (DON) revealed nurses were expected to administer medication per resident. The DON further revealed that nurses were not to label cups and pre-set up the medications for the residents on the hall in advance.During an interview on 9/10/2025 at 3:41 pm, the Administrator revealed nurses were expected to administer medications individually.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of the facilities' policy titled Storage of Medications, Facility A failed to ensure one of one medication storage room did not have expired over the counter (OTC) medications on the shelf and failed to ensure two of two medication carts (Long Hall and the Short Hall) did not have expired medications. In addition, Facility B failed to ensure one of two medication storage rooms (located on Bluebird hall) did not have expired medication on the shelf and failed to ensure one of four medication carts (100-Hall) did not have expired medications. Findings include:Review of the facilities' policy Storage of Medications dated 10/19/2017 under the Policy Statement revealed, The facility shall store all drugs, and biologicals in a safe, secure and orderly manner. Under the section titled Policy Interpretation and Implementation revealed, 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.(Facility A)1. During an observation on 9/9/2025 at 9:28 am with Registered Nurse (RN) CC in the medication storage room located behind the nursing station revealed the following expired medications:One bottle of probiotic formula with an expiration date of 4/2025. One jar of Fleet glycerin suppositories with an opened date of 2/14/2024 and manufacturer expiration date of 4/2025. There were nine suppositories in the jar. During an interview on 9/9/2025 at 10:12 am, RN CC confirmed that the medications had expired. She continued to state that the facility had a discard bin for all expired or discontinued medications for the pharmacy and the Director of Nursing (DON) destructions. 2. During an observation on 9/9/2025 at 10:42 am with Licensed Practical Nurse (LPN) AA of the Long Hall medication cart revealed, the following expired medications on the cart:One bottle of coated aspirin with an expiration of 8/2024.One bottle of aspirin 325 milligram (mg) with an expiration date of 2/2025.One bottle of thiamine B-1 vitamins with an expiration date of 5/2025.One bottle of aspirin 325 mg with an expiration date of June 2025. 3. During an observations on 9/9/2025 at 10:52 am with RN BB of the Short Hall medication cart revealed, the following expired medications on the cart:One bottle of aspirin 325 mg with an expiration date of 2/2025One bottle of ibuprofen 200 mg with an expiration date of 8/2025One bottle of ferrous sulfate with a fade illegible expiration date. During an interview on 9/9/2025 at 1:00 pm, LPN AA revealed that the nurses was responsible for checking the medication carts for expired OTC medications. During an interview on 9/9/2025 at 1:32 pm, RN BB revealed that all nurses were responsible for checking the medication cart for expired medications. During an interview on 9/9/2025 at 1:23 pm, the DON revealed that the nurse that administer medications were responsible for checking medication expiration dates. The DON further revealed that the medication storage room had a secretary who checked the dates on OTC in the medication storage room. (Facility B)4. During an observation on 9/8/2025 at 10:04 am with LPN II in the medication storage room for 100 Hall and 400 Hall located on Bluebird Hall revealed, one bottle of thiamine vitamin B-1 100 mg with an expiration date of 5/2025. 5. During an observation on 9/8/2025 at 10:16 am with LPN FF of the 100 Hall medication cart revealed [NAME]-Vite tablets with an expiration date of 7/2025, a vial of Lantus insulin with an opened date of 8/6/2025 and expiration date of 9/2/2025. Review of a chart on the medication cart revealed, for an opened vial of insulin dated 8/6/2025, that it would expire on 9/2/2025.During an interview on 9/10/2025 at 2:35 pm, the DON confirmed that the Lantus insulin found on the 100 Hall medication cart expired on 9/2/2025.