

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2026
NAME OF PROVIDER OR SUPPLIER  Archbold Living Camilla		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews, record review, and review of the facility's policy titled, Abuse Prohibition Policy and Procedures and Identifying Sexual Abuse and Capacity to Consent, Facility B failed to ensure one of three Residents (R) (R1) was protected from sexual assault by R2. Specifically, R2 was found in R1's room sitting next to her bed. R1 was naked from the waist down with blood noted to her vaginal area and R2 was later found to have blood on his right middle finger. Subsequently, R1 was sent to the hospital after the sexual assault by R2 resulting in a one-centimeter laceration to her left vaginal wall. The facility's failure to ensure protection from the sexual assault had the potential to result in physical, mental, or psychosocial harm. An Immediate Jeopardy (IJ) was identified on 12/29/2025 at 5:00 pm and was determined to have existed on 11/29/2025 at appropriately 6:09 pm. The facility's Administrator for Facility B was notified that an acceptable IJ removal plan was received on 12/30/2025. The surveyor validated the full implementation of the facility's removal plan, and the Administrator was notified on 12/31/2025 at 5:10 pm that the Immediacy had been removed on 12/19/2025. Findings include: Review of the facility's policy titled Abuse Prohibition Policy and Procedures dated 8/25/2008 revealed, under the section titled Prevention revealed, 3(B). The facility will identify, correct and intervene in situations in which abuse, neglect, exploitation and/or misappropriation of resident property is more likely to occur. This will include an analysis of: 4. The assessment, care planning, and monitoring of residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors, residents who have behaviors such as entering other residents' with self-injurious behaviors, residents with communication disorders, those that require heavy nursing care and/or are totally dependent. Review of the facility's policy titled Identifying Sexual Abuse and Capacity to Consent dated August 2024 under the Policy Statement revealed, A resident's consent to sexual activity is not valid if obtained from a resident who lacks the capacity to consent, or if consent was obtained through intimidation, fear or coercion. Under the Policy Interpretation and Implementation revealed, 5. The facility will conduct an investigation and protect a resident from non-consensual sexual relations anytime there is reason to suspect that the resident does not wish to engage in sexual activity or may not have the capacity to consent. 1. Review of the medical records revealed that R1 was admitted to the facility with the following diagnoses that include but were not limited to Alzheimer's disease, hypothyroidism, and atherosclerotic heart disease. Review of R1's Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Pattern) revealed, a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. Review of R1's nursing progress notes dated 11/29/2025 revealed that Certified Nursing Assistant (CNA) AA observed R1 door closed and opened the door to see R2 sitting in his wheelchair next to her bed. CNA AA left the room to get the Licensed Practical Nurse (LPN) BB. They both entered R1 room together and R2 was immediately wheeled out and taken to his</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115266
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>room. R1 brief was observed lying next to her pillow. LPN BB then lowered the flat sheet and noted that R1 was naked from the waist down. LPN BB performed a skin assessment on R1 and then assisted R1 to a standing position where she noted blood on the sheets. During this assessment, LPN BB observed a moderate amount of blood in the vaginal area and dried blood on the outer skin of the vaginal area. R1 was sent to the hospital for a sexual assault examination. Review of the local hospital records dated 11/29/2025 revealed R1 was treated and discharged to a another facility on 11/29/2025 at 9:21 pm to be evaluated by Sexual Assault Nurse Examiner (SANE) nurse. Review of the SANE examination dated 11/30/2025 at 12:11 am revealed, the sexual assault type as, vaginal penetration with associated symptoms of vaginal bleeding. Further review of the the examination revealed that R1 had a one-centimeter laceration noted to the left vaginal wall without active bleeding.2. Review of the medical records revealed R2 was admitted to the facility with the following diagnoses that included but are not limited to dependence on renal dialysis, end stage renal disease, cardiac arrhythmia, hypertension, syncope and collapse. Review of R2's Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Pattern) revealed, a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. Review of R2's nursing progress notes dated 11/29/2025 revealed R2 hand was examined, and LPN BB saw dry red blood on his right middle finger. R2 reported to LPN BB that he did not know why his finger was that color. Law enforcement arrived at facility. R2 was transferred to emergency room for evaluation to an inpatient behavioral unit. Review of [Name] PD Incident Report dated 11/29/2025 under section titled Officer Supplementals when questioned by the officer what occurred in R1's room while the door was closed, R2 revealed that he put his wheelchair beside her bed and placed his fingers into the vagina of R1. The officer then observed blood on a finger from his right hand that appeared to be dried up and stained. Review of the Facility Incident Report Investigation Summary dated 11/29/2025 revealed, that R2 was later discharged from the inpatient behavioral unit to home with family. The report further noted that R2 was issued a 30-day discharge on [DATE]. On 12/4/2025, law enforcement reported formal charges would be filed against R2. During an interview on 12/18/2025 at 11:06 am, LPN BB revealed she was sitting at the nurse's station charting. CNA AA came to the desk to say that R1 room door was closed. She stated that she got up and saw LPN XXX on the hall. LPN XXX stated that R1 was not in her right mind and someone needed to check on her. LPN BB and CNA AA opened the door and peeked inside and at first they didn't see anything strange. R1 had on a jacket and a shirt and a sheet was covering the lower portion of her body from the waist down. She revealed that she and CNA AA came out of the room together. CNA AA then asked her if she had seen the pull-up next to the pillow. She stated to CNA AA that she had not seen the pull-up by the pillow. LPN BB stated that she went back into the room and saw the brief by the pillow. She then moved the sheet and saw that R1 was naked from the waist down. R2 who was sitting in his wheelchair next to R1's bed was rolled out and taken to his room. She revealed that she assisted R1 to standing position while doing a skin assessment and noted blood on the sheets. She went out of the room after the assessment to get LPN XXX who told her to call the Administrator. R1 was examined by her and LPN XXX while CNA AA held the flashlight, and she was able to see a medium amount of dry blood outside of the vagina area. She called the Administrator again to tell her about the blood. She revealed that the Administrator called the police and she completed the paperwork to send R1 to the hospital. She attempted five times to contact R1's family but no answer. She revealed, after the incident, she checked R2's hand and saw dried blood on his middle finger. During an interview on 12/18/2025 at 12:06 pm, CNA AA revealed she observed R1 lying in her bed and R2 sitting in his wheelchair in the doorway of R1's room watching television. CNA AA revealed that she was later walking down the hall and</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>saw R1's room door closed. She revealed that when she went to the door and opened it, R2 was sitting in his wheelchair and R1 was in bed. She then closed the door to go get the nurse to make sure it was okay for R2 to be in R1's room. She revealed they both went to R1's room and shocked to see R1's brief at the head of the bed. While standing in the hallway, she then asked LPN BB if she saw the brief on the bed near the pillow. LPN BB stated that she had not seen the brief by the pillow, and then they both went back into the room. CNA AA stated that she assisted LPN BB with the body assessment, and when the sheet was pulled back, R1 was naked from the waist down and there were streaks of blood on the sheets. She revealed that the brief by the pillow did not have any blood on it. She further revealed when she began putting on a new brief for R1, blood started to leak on the brief. She took off the brief and put that brief in the trash bag. A second brief was placed on R1 and a yellow discharge substance was noted it. She stated when the police came, they completed an assessment for R1 then check R2 and noticed blood on his right middle finger.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews, record reviews, and review of the facility's policy titled Falls and Falls Risk Management, Facility A failed to ensure four of four Residents (R) (R1, R2, R3, R4) reviewed for falls had fall risk assessments, 3 (three)-day post fall follow-up, and/or neurological checks completed to prevent the risks and minimize complications from falls. Findings include: Review of the facility's policy titled Falls and Falls Risk Management, dated August 2019 under the Policy Statement revealed, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Under the Policy Interpretation and Implementation subsection titled Prioritizing Approaches to Managing Falls and Fall Risk revealed, 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions, (i.e., to try one or a few at a time, rather than many at once). Under the subsection Monitoring Subsequent Falls and Fall Risk revealed, 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 1. Review of the medical record revealed R1 was admitted with the following diagnoses that included but were not limited to Alzheimer's disease, type 2 diabetes mellitus, dementia, and unsteadiness on feet. Review of the nursing notes dated 4/16/2025 through 11/30/2025 revealed an entry on 10/9/2025 that indicated, R1 had an unwitnessed fall in the hallway without an apparent injury. There was no evidence that there was a 3-day post fall follow-up on 10/10/2025, 10/11/2025 and 10/12/2025. An entry dated 11/20/2025 revealed R1 had an unwitnessed fall in her room and a neurological assessment was initiated; however, the neurological checks were incomplete and did not follow the correct timing protocol. In addition, there was no evidence of a post fall assessment completed on 11/21/2025, 11/22/2025, and 11/23/2025. Further review of the nursing notes dated 11/26/2025 revealed R1 was lying flat on the floor at bedside. She was noted to have redness to top of left foot, a skin tear to her left elbow. Review of monitoring documentation dated 10/9/2025, 11/19/2025 and 11/26/2025 revealed no evidence of a post fall follow-up. Review physical therapy initial assessment dated [DATE] revealed R1 was a fall risk. Review of R1's medical record revealed, there was no evidence of fall assessments completed. 2. Review of the medical records revealed, R2 was admitted to the facility with the following diagnoses that included but were not limited to cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, hypertension, adult failure to thrive and chronic pain. Review of the nursing notes dated 11/19/2025 through 12/5/2025 revealed an entry dated 11/19/2025 that indicated, R2 had an unwitnessed fall in his room without any injuries. The neurological checks were incomplete and did not follow the correct timing protocol. In addition, there was no evidence of a 3-day post fall follow-up. An entry dated 11/27/2025 revealed R2 had an unwitnessed fall in his bathroom without injury. There was a follow up on 11/27/2025 for a fall listed on 11/26/2025 and a late entry on 11/28/2025 for 11/27/2025. There was no evidence of a completed 3-day post fall follow-up. An entry dated 12/1/2025 revealed an unwitnessed fall in his room without apparent injury. The neurological checks were incomplete and did not follow the correct timing protocol. In addition, there was no evidence of a 3-day post fall follow-up. Review of R2 fall risk assessments dated 2/1/2023, 5/3/2023 and 8/1/2023. There was no evidence for fall risk assessments for the year of 2024 and 2025. 3. Review of the medical records revealed R3 was admitted to the facility with the following diagnoses that included but were not limited to palliative care,</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>cerebral infarction, hypertensive, and dysphasia. Review of the nursing notes dated 10/6/2025 through 10/30/2025 revealed an entry dated 10/7/2025 that indicated R3 had a witnessed fall. There was no evidence of a 3-day post fall follow-up. An interview on 1/8/2025 at 9:43 am with Licensed Practical Nurse (LPN) BB revealed the Certified Nursing Assistant (CNA) reported the fall to her on 10/7/2025. She revealed that she assessed the resident for injuries and notified the physician and responsible party. She confirmed that after a fall, 3-day post fall follow-up should have been completed. LPN BB revealed, when a fall was entered in the computer, it should have populated the 3-day post fall follow-up. She further revealed that fall risk assessments were done on admission and with the monthly summary completed by the nurses. She revealed with any unwitnessed fall or head injuries, that neuro checks should be done. 4. Review of the medical records revealed R4 was admitted to the facility with the following diagnoses that included but were not limited to Alzheimer's disease, dementia, and hypertension. Review of the nursing notes dated 10/10/2025 through 12/4/2025 revealed an entry dated 10/10/2025 that indicated, R4 had an unwitnessed fall. There was no evidence of a 3-day post fall follow-up for 10/12/2025. The neurological checks were incomplete and did not follow the correct timing protocol. An entry dated 12/4/2025 revealed an unwitnessed fall in R4's bathroom without injuries. There was no evidence of the 3-day post fall follow-up and incomplete neurological checks for the unwitnessed fall. Review of R4's care plan revealed, There was a fall dated 10/12/2025 listed on the care plan however, there was no other evidence of documentation related to the fall. An interview on 1/8/2026 at 11:00 am with Registered Nurse (RN) FF revealed that R4 had a fall on 10/10/2025 and her roommate called for help. RN FF stated she assessed R4 for injuries; obtained vital signs and notified the responsible party and physician. She revealed that the post fall documentation is a three day follow up and that she charted her post fall follow up under the nurses note - fall charting tab. An interview on 1/8/2026 at 12:28 pm with the Director of Nursing (DON) revealed that the electronic medical records had a glitch in the system and was not triggering the 3-day post fall follow ups. She revealed that there were a couple of different places to enter the post fall. However, there was one tab with a folder that will trigger the 3-day post fall follow up and that she would see if the electronic medical services would take out the sections that did not trigger the 3-day post falls. The DON further revealed that an unwitnessed fall or falls with head injuries were to have neurological checks and that the computer system did not allow nurses to complete neuro checks. The nurses were to complete the neuro checks on a paper form. The DON stated that she would initiate training so that the nurses know how to complete the neuro checks. An interview on 1/8/2026 at 12:57 pm with the Administrator revealed the expectation was that residents assessments and neurological checks were to be completed and to follow the fall policy.</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews, record reviews, and review of the facility's policy titled Resident Rights, Standards of Performance Nursing Home Administrator (PPNH), and Standards of Performance Director of Nursing (PPNH), Facility B failed to ensure one of three Residents (R) (R1) was protected from sexual assault by R2. Specifically, Administration failed ensure R1 maintain an environment free from abuse in a manner that efficiently maintained the highest practicable physical, mental, and psychosocial well-being for the resident. The facility's failure to ensure protection from the sexual assault had the potential to result in physical, mental, or psychosocial harm. An Immediate Jeopardy (IJ) was identified on 12/29/2025 at 5:00 pm and was determined to have existed on 11/29/2025 at approximately 6:09 pm. The facility's Administrator for Facility B was notified that an acceptable IJ removal plan was received on 12/30/2025. The surveyor validated the full implementation of the facility's removal plan, and the Administrator was notified on 12/31/2025 at 5:10 pm that the Immediacy had been removed on 12/31/2025. Findings include: Review of the facility's policy titled Resident Rights dated August 2019 under the section titled Policy Interpretation and Implementation revealed, 1.c. be free from abuse, neglect, misappropriation of property, and exploitation. Review of the facility's policy titled Standards of Performance Nursing Home Administrator revealed, under Required Skills: 1. The Administrator shall exercise general management of the Nursing Home. 5. Be responsible to assure that high standards of quality patient care are maintained. Review of the facility's policy titled Standards of Director of Nursing revealed, under Performance Standards: Makes a conscientious effort to help maintain a clean, safe and secure environment. 1. Review of medical records for R1 revealed, she was admitted to the facility with the following diagnoses that include but were not limited to Alzheimer's disease, hypothyroidism, and atherosclerotic heart disease. Review of the Minimum Data Set (MDS) assessment for R1 dated 9/1/2025 under Section C (Cognitive Pattern) revealed, a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. Review of R1's nursing progress notes dated 11/29/2025 revealed that Certified Nursing (CNA) AA observed R1 door closed and opened the door to see R2 sitting in his wheelchair next to her bed. CNA AA left room to get Licensed Practical Nurse (LPN) BB. When they both arrived at R1's room together, they observed R1's brief lying next to her pillow. R2 was removed from R1's room and wheeled to his room. LPN BB then lowered the flat sheet and noticed that R1 was naked from the waist down. LPN BB performed a skin assessment on R1 and then assisted R1 to a standing position where she noted blood on the sheets. During this assessment, LPN BB observed a moderate amount of blood in the vaginal area and dried blood on the outer skin of the vaginal area. R1 was sent to the hospital for a sexual assault examination. Review of the examination performed by the Sexual Assault Nurse Examiner (SANE) dated 11/30/2025 at 12:11 am revealed, the sexual assault type as, vaginal penetration with associated symptoms of vaginal bleeding. Further review of the examination revealed that R1 had a one-centimeter laceration noted to the left vaginal wall without active bleeding. 2. Review of R2's medical records revealed, he was admitted to the facility with the following diagnoses that included but are not limited to dependence on renal dialysis, end stage renal disease, cardiac arrhythmia, hypertension, and syncope and collapse. Review of the Minimum Data Set (MDS) assessment for R2 dated 11/11/2025 under Section C (Cognitive Pattern) revealed, a Brief Interview for Mental Status (BIMS) score of five, which indicated severe cognitive impairment. Review of [Name] PD Incident Report dated 11/29/2025 under the Officer Supplementals section, it was revealed when questioned by the officer that R2 stated he put his wheelchair beside R1's bed and placed his fingers into R1's vagina. The officer noted blood on R2's right finger that</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>appeared to be dried up and stained. Review of the Facility Incident Report Investigation Summary dated 11/29/2025 revealed, R2 was later discharged from the inpatient behavioral unit to home with family. Further review revealed, R2 was issued a 30-day discharge on [DATE]. On 12/4/2025, it was reported that law enforcement would file formal charges against R2. During an interview on 12/31/2025 at 2:00 pm, the Administrator revealed that there was no indication of any behaviors that would trigger R2 outcome. The Administrator revealed he had no evidence in his past medial history that would indicate a reason to decline his admission to the facility. The Administrator revealed immediately after the sexual assault, she did a timeline of the incident, in-service on sexual abuse, involved law enforcement and discharged R2 from the facility. The Administrator further revealed, R1 was sent to the hospital for a sexual assault examination. The Director of Nursing (DON) was on leave, and an interview was not obtained.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, staff interview, record review and review of the facility's policy titled Perineal Care, Facility A failed to ensure one of four Residents (R) (R8) with pressure ulcers was provided perineal care in a sanitary manner to prevent cross contamination of loose stool to a clean area. This deficient practice had the potential to place the resident at risk for infection. Findings include: Review of the facility policy Perineal Care dated 4/2022 under the section titled, PURPOSE revealed, The purpose of this policy is to cleanse the skin and perineum to promote healing and patient comfort. Under the section titled Policy revealed, It is the policy of (named facility) to provide cleansing of the perineum following voiding, defecation, or during bathing for dependent patients or patients that may need partial assistance. Review of the medical record revealed R8 was admitted to the facility with the following diagnoses that included but are not limited to Alzheimer's disease, heart failure, rhabdomyolysis, cerebral infarction and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of R8's Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Section C (Cognitive Patterns) revealed a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderate cognitive impairment; Section GG (Functional Abilities and Goals) revealed, the resident was dependent with toileting hygiene; Section M (Skin Conditions) revealed, she had one unhealed stage 3 pressure. Review of weekly skin assessments dated 12/8/2025 and 12/15/2025 revealed a resolving sacrum wound. Weekly skin assessments dated 12/19/2025 and 12/23/2025 revealed a closed sacrum wound. An observation on 12/29/2025 at 2:15 pm revealed R8's door had an infection control personal protective equipment container (PPE) on the door that was empty except for a partially filled bottle of hand sanitizer. An enhanced barrier sign was posted next to the door. Licensed Practical Nurse (LPN) AA entered the room and R8 asked to be changed. Surveyor observed R8 lying on her back on an air flow mattress with loose stool between her thighs that had leaked from her brief. LPN AA failed to put on a protective gown as a barrier to the loose stool. LPN AA explained to the resident that she was going to clean her. She rolled the soiled incontinent brief toward the back and took wipes to clean the front of the resident. When LPN AA assisted R8 to her side facing the window, she removed the rolled brief and took a clean wipe and began cleaning the buttocks and sacral area. She then took another wipe to clean between her thighs where the loose stool was settling. Afterward using the same wipe, she wiped over R8's buttock and sacral area with the dirty wipe. During an interview on 1/7/2026 at 3:13 pm, LPN AA revealed that she didn't have a bag to put her dirty items into. She confirmed that she took a dirty wipe and wiped over the clean area. She confirmed she did not reclean the sacral and buttock area and admitted that she did not do the procedure correctly and had messed up. LPN AA continued to state that she did not wear a gown because there was not one available, and she was supposed to wear a gown because of the loose stool.</p>		