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	05/16/2025

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to ensure residents were informed of the risk versus the benefits of psychotropic medication use prior to being administered psychoactive medications for two of five (Resident (R) 79, and R38) reviewed for unnecessary medications out of 31 sampled residents. This failures placed the residents at risk for receiving unnecessary medications. Findings include: Review of the facility's policy titled, Resident Rights dated 08/2019 revealed, .1. Federal .laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .participate in decision-making regarding his or her care . 1. Review of R79's undated Admitting and Discharge Record provided by the facility revealed admitted to the facility on [DATE] with diagnosis of major depressive disorder. Review of R79's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 04/08/25 and found under the Aspen MDS Viewer revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. The MDS also indicated the facility assessed the resident to have active diagnoses which included anxiety disorder, depression, and dementia and that the resident received antipsychotic medication and an antianxiety medication during the assessment period. Review of R79's [Name of contracted behavior health practice] Patient Intake Form dated 01/21/25 and provided by the facility revealed, Consent for Treatment. I consent to .psychological, psychiatric, or other behavioral health services. I understand that behavioral health treatment may result in unexpected side effects, such as intense or uncomfortable emotions, and that it is important that I discuss any reactions to my treatment with my treating clinician. Behavioral health treatment can also provide benefits, such as a significant reduction in feelings of stress and improved self-esteem. I am aware, however, that no guarantees have been made to me about the results of services . The Intake Form was signed by a resident representative and not by the resident and it was signed prior to the resident's admission to the facility. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R79's Physician Orders provided by the facility revealed an order dated 01/25/25 for Melatonin [a natural herbal supplement used as a hypnotic medication] 3MG [milligram] tablet oral two tablets by mouth at bedtime for insomnia .mirtazapine [an antidepressant medication 15mg tablet oral one by mouth at bedtime for appetite stimulant. Review of the Physician Orders dated 01/27/25 indicated, Geodon (an antipsychotic medication) 20mg capsule Oral one by mouth BID[twice a day] .for major depressive disorder . and physician orders dated 03/03/25 indicated trazodone (an antidepressant medication) 100mg tablet oral one at bedtime for insomnia . During an interview on 05/15/25 at 9:55 AM, R79 stated she had not been explained the risk versus benefits of any of her medications. The resident also indicated she should be the one the facility's doctor should be explaining her medications to. 2. Review of R38's undated Admitting and Discharge Record, provided by the facility revealed the resident was admitted to the facility on [DATE] with diagnosis of major depressive disorder. Review of R38's annual MDS with an ARD of 04/29/25 and found under the Aspen MDS Viewer revealed a BIMS score of two out of 15 which indicated the resident was severely cognitively impaired. The MDS also indicated active diagnoses which included dementia and depression. The MDS further indicated that the resident received antipsychotic medication and an antidepressant medication during the assessment period. Review of R38's [Name of contracted behavior health practice] Patient Intake Form dated 02/13/23 and provided by the facility revealed, Consent for Treatment. I consent to .psychological, psychiatric, or other behavioral health services. I understand that behavioral health treatment may result in unexpected side effects, such as intense or uncomfortable emotions, and that it is important that I discuss any reactions to my treatment with my treating clinician. Behavioral health treatment can also provide benefits, such as a significant reduction in feelings of stress and improved self-esteem. I am aware, however, that no guarantees have been made to me about the results of services . The Intake Form was signed by a resident representative and it was signed prior to the resident's admission to the facility. Review of R38's Physician Orders, provided by the facility revealed on 03/27/24 the resident was ordered bupropion (an antidepressant medication) ER [extended release] 150mg tablet extended release 24 hour oral one at bedtime for major depressive disorder. Continued review of the Physician orders revealed on 01/21/25, R38 was ordered Seroquel (an antipsychotic medication) 100mg tablet oral one BID. for agitation, Depakote (an anticonvulsant medication used off label to treat mood disorders) ER 500mg tablet extended release 24 hour two tabs [tablets] oral by mouth daily for mood disorder and mirtazapine (an antidepressant medication) 15mg tablet oral one by mouth at bedtime for mood. During an interview on 05/15/25 at 12:51 PM, Infection Preventionist (IPA) reviewed R38 and R79's Intake Form and confirmed that the consent section of both forms did not indicate the risk and benefits for use of any medications. During an interview on 05/16/25 at 1:41 PM, Director of Nursing (DON)A stated she thought education was being provided for psychoactive medication use. DON A stated it was her expectation the resident and/or the resident's representative would have been educated on the risks of each psychotropic medication prescribed prior to the medication being administered. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/25 at 2:03 PM, Administrator A stated it was her expectation that anytime a new medication was prescribed to a resident, the resident and/or the resident representative was educated on the medication and the resident and/or resident representative give consent for the medication prior to the use of the medication.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, Facility B failed to ensure residents were informed in advance of their right to attend and participate in their care plan conference for two of four residents reviewed for care planning (Resident (R) 28 and R79) out of 31 sampled residents. This failure placed the residents at risk for their care plans not being person centered. Findings include: Review of the facility's undated policy titled, Care Planning revealed .Our facility's Care planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .3. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. 4. Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family . Review of the facility's policy titled, Resident Rights, dated 08/2019 revealed .1. Federal laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .p. be informed of, and participate in, his or her care planning and treatment . 1. Review of R28's undated Admitting and Discharge Record provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R28's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/11/25 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident was severely cognitively impaired. On 05/14/25, a request to the Social Service Director (SSD) A to assess R28's mental status score. Review of R28's BIMS completed on 05/14/25 by SSDA revealed R28 was assessed to have a score of 14 out of 15 which indicated the resident was cognitively intact. During an interview on 05/14/25 at 11:4 AM, R28 stated she had not been invited or attended a care plan meeting since her admission. R28 stated this was something she wanted to be a part of. Review of R28's document titled, Care Plan Conference dated 12/31/24 and 03/11/25, and provided by the facility revealed under the Signature section, where the resident was to sign during attendance was blank, which indicated the resident was not present during either meeting. 2. Review of R79's undated Admitting and Discharge Record provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R79's quarterly MDS with an ARD of 04/08/25 and found under the Aspen MDS Viewer with a BIMS score of 14 out of 15 which indicated the resident was cognitively intact. The MDS also indicated the facility assessed the resident to have active diagnoses which included anxiety disorder. The MDS further indicated the resident received an antipsychotic medication and an antianxiety medication during the assessment period. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25 at 9:55 AM, R79 stated she had not been invited nor attended her care plan conferences since her admission. R79 also stated she would want to attend since she had not been asked about her discharge goals. Review of R79's document titled, Care Plan Conference dated 01/28/25 and 04/08/25, and provided by the facility revealed under the Signature section, where the resident was to sign during attendance was blank, which indicated the resident was not present during either meeting. During an interview on 05/14/25 at 4:39 PM, the Activity Director (AD) stated she was the person responsible for notifying and inviting the residents to their care plan conferences. The AD reviewed the Care Plan Conference documents for both R28 and R79 and confirmed the documents did not contain the residents' signatures to indicate they attended. The AD further stated she had not passed out the invitations inviting the residents to attend. During an interview on 05/16/25 at 1:41 PM, the Director of Nursing (DON) stated it was her expectation that residents were invited to their care plan meetings as the care plan meeting was for the resident to know their expected goals. During an interview on 05/16/25 at 2:03 PM, the Administrator stated it was her expectation that all residents were invited to their care plan conferences.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview, record review, and facility policy review, Facility A failed to obtain the CMS-10055 (Centers for Medicaid and Medicare Services) Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) and CMS-10123 Notice of Medicare Non-Coverage (NOMNC) for one of five residents (Resident (R) 136) when Part A Medicare services ended. This failure prevented R136 or responsible party from appealing the decision of the facility and/or making an informed decision related to the cost of continued therapy services. Findings include: Review of the facility policy titled Advance Beneficiary Notifications dated 03/2013 revealed, The purpose is to provide instructions for issuing Advance Beneficiary Notice to applicable Medicare patients so that the patient may make an informed decision as to whether they will receive noncovered items or services for which they may have to accept financial responsibility. Review of R136's medical record revealed R136 was admitted to Medicare part A therapy services on (no date listed). R136's last covered day of Part A service was 05/03/25. CMS-10055 and CMS-10123 were emailed to R136's power of attorney (POA) on 04/30/25 at 3:30 PM. The POA did not respond to the email and there was no follow-up by the facility to acquire the beneficiary notification paperwork. Since R136 remained in the facility, Form CMS-10055 SNFABN and CMS Form 10123 NOMNC should have been reviewed by the POA to make an informed decision related to the cost of continuing to receive Part A therapy and how to appeal the decision made by the facility to discontinue Part A therapy services. Interview on 05/15/25 at 1:53 PM, the Administrator revealed, A follow-up to the POA should have been completed by calling to make sure that they had received the email.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Facility A failed to provide a timely quarterly Minimum Data Set (MDS) Assessment data submission for one (Resident (R)78) of one resident reviewed for MDS over 120 days old out of a total sample of 31 residents. Findings include: Review of R78's undated Face Sheet provided by the facility revealed R78 was admitted to the facility on [DATE] with a diagnosis of hemiplegia and hemiparesis following cerebral infarction. Review of R78's quarterly MDS Assessment with an Assessment Reference Date (ARD) of 02/24/25 provided by the facility revealed it was completed on 02/25/25. Review of R78's MDS 3.0 Missing OBRA Assessment Report run date 05/07/25 provided by the facility revealed . Last Record Identifiers: . Target Date 12/03/24. During an interview on 05/15/25 at 9:58 AM, the MDS Coordinator (MDSC) B indicated she completed the quarterly MDS on 02/24/25 and submitted it on 02/25/25. MDSCB also indicated she ran the validation report after she submitted the quarterly assessment, however, the validation did not show it was accepted by CMS, and she did not resubmit the MDS. The MDSCB stated she ran the missing MDS 3.0 OBRA assessment report on 05/07/25 but did not understand that report stated the last MDS accepted was the quarterly assessment on 12/03/24. The MDSCB confirmed she resubmitted the assessment on 05/14/25 and the validation report stated it was accepted after the surveyor inquired about the missing assessment. The MDSCB stated she followed the RAI User's Manual which stated MDS assessments must be transmitted within 14 days of the completion date. During an interview on 05/15/25 at 10:36 AM, the Director of Nursing (DON) stated she expected the MDSCB to transmit the MDS assessments within 14 days of the completion date and to run the validation reports after the assessments were submitted to ensure they were accepted by CMS. Review of CMS LTC RAI 3.0 User's Manual, Chapter 5.2 Timeliness Criteria indicated, . Transmitting Data: Submission files are transmitted to the Quality Improvement and Enhancement System (QIES) Assessment Submission and Processing (ASAP) system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 . Transmission requirements apply to all MDS 3.0 records used to meet both federal . requirements . Assessment Transmission: . All other MDS assessments must be submitted within 14 days of the MDS Completion Date .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, Facility B failed to develop care plans related to bed rail use for two of four residents reviewed for care planning (Resident (R) 28 and R75) out of 31 sampled residents. This failure placed the resident at risk for unmet care needs and increased risks of accidents. Findings include: Review of the facility's undated policy titled, Care Planning revealed, Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .2. The care plan is based on the resident's comprehensive assessment . Review of the facility's policy titled, Using Care Plan dated 11/2018 revealed, .The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. 1. Review of R28's undated Admitting and Discharge Record provided by the facility revealed the resident was admitted to the facility on [DATE]. During an observation on 05/14/25 at 11:12 AM, R28 was lying in bed with raised bilateral ¾ bed rails on her bed. Review of R28's Care Plan provided by the facility revealed a care plan had not been developed related to the use of bed rails. 2. Review of R75's undated Admitting and Discharge Record, provided by the facility revealed the resident was admitted to the facility on [DATE]. During an observation on 05/14/25 at 10:44 AM, R75 was lying in bed with raised ¾ bilateral bed rails on her bed. During an interview on 05/16/25 at 12:53 PM, Minimum Data Set Coordinator (MDSC) A reviewed R28's and R75's Care Plan and confirmed a care plan related to bed rail use was not developed for either resident. MDSCA stated the residents' care plans should have reflected their use of bed rails. During an interview on 05/16/25 at 1:41 PM, the Director of Nursing (DON) stated it was her expectation residents' care plans were reviewed every day to ensure there were no inconsistencies. The DON also stated if the residents have bed rails on their bed, it should be on their care plan that they use bed rails. During an interview on 05/16/25 at 2:03 PM, the Administrator stated it was her expectation that residents who had bed rails would have had a care plan developed to reflect the bed rail use.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, Facility B failed to review and revise residents' care plans for one of four residents review for care planning (Resident (R) 50). R50's care plan was not revised to reflect his current status. This failure placed the resident at risk for unmet care needs. Findings include: Review of the facility's policy titled, Using Care Plan, dated 11/2018 revealed, The care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident .5. Changes in the resident's condition must be reported to the MDS [Minimum Data Set] Assessment Coordinator so that a review of the resident's care plan can be made . Review of R50's undated Admitting and Discharge Record provided by the facility revealed the resident was readmitted to the facility on [DATE]. Review of R50's Physician Orders provided by the facility revealed on 03/31/25 the resident was ordered Diet: NPO [nothing by mouth] Tube Feeding and on 05/08/25 Tube Feeding Osmolite 1.2 @ [at] 20 ml/hr. [milliliters an hour] advancing by 10 cc [cubic centimeters] every 4 hours to goal of 60 cc/hr . The orders did not include any treatments ordered for wounds or pressure. Ulcers. Review of R50's Care Plan provided by the facility revealed .Need/Preference-I have a skin injury to my left and right buttocks. Stage 2 [pressure] because I don't receive the proper nutrition need .Approach: Reduce pressure and friction between myself and my bed or chair .provide me with wound care per POC [plan of care] .use pressure redistribution devices .low air loss mattress (initiated on 01/03/25) .Need/Preference- I can't complete my cares on my own .Approach: I EAT: supervision or touching assistance (initiated on 05/07/25) . Review of R50's Weekly Skin Assessment dated 05/02/25 and provided by the facility revealed, No open areas and that the pressure ulcer was healed in April 2025. During an interview on 05/15/25 at 10:43 AM, the Infection Preventionist (IP) A reviewed R50's care plan and confirmed the resident did not have any wounds or pressure ulcers. IPA confirmed the resident did not have a low air loss mattress. The IP also stated R50 was NPO and received tube feedings. The IP further stated the resident's care plan should have been revised to reflect the resident's current status of no skin issues, having a pressure reducing mattress and not a low air loss mattress, and not indicating the resident consumed food by mouth. During an interview on 05/16/25 at 1:41 PM, the Director of Nursing (DON)A stated it was her expectation that the resident's care plan would have been gone over every day to ensure there were no inconsistencies and that it was correct for continuation of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/16/25 at 2:03 PM, Administrator A stated it was her expectation that R50's care plan would have been revised for any change in status to reflect the resident's current status.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, Facility B failed to ensure residents who were dependent on staff for activities of daily living (ADLs) received showers for one of two residents (Resident (R) 28) reviewed for ADLs out of 31 sampled residents. This failure placed the resident at risk for an undignified quality of life. Findings include: Review of the facility's policy titled, Bath, Shower/Tub dated 06/07/24 revealed, The purpose of this procedure are [sic] to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. General Guidelines .5. Baths are given per bath schedule .Documentation. 1. The date and time the shower/tub baths was performed per bath schedule .5. If the resident refused the shower/tub bath, the reasons(s) . Review of R28's undated Admitting and Discharge Record, provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R28's quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/11/25 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident was severely cognitively impaired. On 05/14/25, a request to the Social Service Director (SSD) A to assess R28's mental status score. Review of R28's BIMS completed on 05/14/25 by SSDA revealed R28 was assessed to have a score of 14 out of 15 which indicated the resident was cognitively intact. During an interview on 05/13/25 at 11:46 AM, R28 stated she wanted to receive showers instead of bed baths; however, the aides only gave her bed baths. Review of R28's untitled shower/bathing documentation records provided by the facility revealed the resident received bed baths on 03/03/25, 03/05/25, 03/06/25, 03/07/25, 03/11/25, 03/12/25, 03/14/25, 03/17/25, 03/20/25, 03/29/25, 04/04/25, 04/07/25, 04/09/25, 04/12/25, 04/13/25, 04/18/25, 04/21/25, 04/22/25, 04/23/25, 04/27/25, 05/01/25, 05/05/25, and 05/11/25. There was no evidence during these documented dates that the resident refused a shower and requested a bed bath. The shower/bathing documentation from 03/01/25 through 05/11/25 documented the resident received one shower. It was documented on 03/10/25 shower given .Resident fussed the entire shower, wanted to use the shower bed but complained the entire time, both CNA [Certified Nursing Assistant] and Restorative Aides bathe resident but resident still complained of itching and continued to scratch her body (buttocks area) until it bled. During an interview on 05/15/25 at 3:36 PM, CNA2 reviewed the shower documentation and confirmed the resident received baths on the above dates and confirmed no documented evidence of shower refusals for the dates. CNA2 stated during showers, R28 does a lot of screaming. CNA2 stated the resident was scared she was going to fall. CNA2 stated that she gives her a bed bath unless she asks specifically for a shower. CNA2 stated if the resident was to refuse a shower, the CNAs should be documenting the refusal on the shower documentation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25 at 3:44 PM, CNA3 stated R28 did not like using the mechanical lift for transfers. CNA3 also stated that sometimes R28 screamed and complained during showers; however, after the shower, the resident was always satisfied. CNA3 further stated, depending on R28's mood, it was easier for both the CNAs and the resident for the resident just to receive a bed bath. During an interview on 05/16/25 at 1:41 PM, the Director of Nursing (DON)A stated R28 should have been given or offered a shower if that was her preference; however, if the resident refused the shower, the refusal should have been documented. During an interview on 05/16/25 at 2:03 PM, Administrator A stated if a shower was the resident's preference, then a shower should have been offered. If the resident refused the shower and wanted a bed bath instead, it was her expectation the CNAs would have documented the resident refuse the shower.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, Facility A failed to ensure one of four residents (Resident (R) 73) reviewed for pressure ulcers out of a sample of 31 residents did not develop facility acquired pressure ulcers. This failure to not identify a pressure ulcer until it was a Stage II had the potential to escalate to a higher level causing the resident pain and discomfort. Findings include: Review of the facility's policy titled, Pressure Ulcer dated 01/17 revealed, The purpose is to standardize a system-wide protocol that identifies those patients at risk for breakdown and to provide guidelines to prevent pressure ulcer occurrence .Maintain and improve tissue tolerance to pressure in order to prevent injury. All individuals at risk should have skin inspected every shift, paying particular attention to bony prominences and areas under medical devices . Review of R73's undated admission Record located in the electronic medical record (EMR) under the Profile tab revealed R73 was admitted to the facility on [DATE] with diagnosis that included encounter for palliative care, stroke, and gastrostomy status. Review of R73's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/27/25 located in the EMR under MDS tab revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated severe cognitive impairment. Review of weekly skin assessments provided by the facility dated 02/27/25; 03/06/25; 03/13/25; 03/20/25; 03/27/25; and 04/03/25; all stated that there were no open areas to the skin. Review of Wound care documentation provided by the facility stated the acquired date was 03/04/25 and was described as Pressure injury Stage II to Peg Site. Depth is 0.3 cm [centimeter], and the length x width is 3.5 cm x 1 cm. The area is reddened with light drainage. Pressure ulcer resolved on 04/02/25. Interview on 05/14/25 at 1:38 PM, Licensed Practical Nurse/Wound Care (LPN 1/WC) revealed, A note was left at the nurse's station for me to look at R73 for an open area by the peg tube site. When I looked under the plastic external bumper that is next to the skin and holds the tube in place, there was a Stage II pressure ulcer. This did not happen in one day and there was no gauze or foam under the bumper next to the skin. There was not an order for gauze under the plastic bumper, but there is now. I do not know how this was missed on weekly skin assessments or how it was not noticed during routine care of the peg tube site. During an interview on 05/14/25 at 3:10 PM, the Director of Nursing (DON) revealed, It does not state in the facility policy that gauze needs to be placed under the plastic bumper. It states to keep the skin clean and dry. Although, this is considered standard of care and does not require an order. This pressure ulcer would have happened earlier if a sponge or gauze were not used. I think that whoever cared for the resident last, did not use anything and developed. I cannot tell you what happened or why it was not documented by who found it. This is very upsetting. Gastrostomy care is gone over upon orientation on the skills check list. All nurses know proper care for gastrostomy tubes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/15/25 at 1:55 PM, the Administrator revealed, We need to do skin checks and make sure that things are done properly and according to policy and standards.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, Facility A failed to monitor a resident's bathroom door protector to ensure it did not injure the resident until the door was replaced for one of seven residents reviewed for accidents out of 31 sampled residents (Resident (R) 64). This failure had the potential to cause injury to the resident. Findings include: Review of R64's undated Face Sheet, provided by the facility, revealed she was admitted to the facility on [DATE] with diagnoses that included Type 2 diabetes mellitus with hyperglycemia, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of R64's quarterly Minimum Data Set (MDS) Assessment, with an assessment reference date (ARD) of 03/14/25, provided by the facility, revealed she had a Brief Interview for Mental Status (BIMS) score of 15 which indicated she was cognitively intact. Review of the facility's Work Order, dated 04/16/25, provided by the facility, revealed The panel on the outside of the bathroom door is coming off in room [ROOM NUMBER]. Patient says she keeps getting [sic] her hand on it when she is going in and out of the bathroom. 04/17/25 [Facilities Management Supervisor] went and placed some duct tape on side of door until [he] can get [vendor] here to measure and get new door ordered. Should be here in the next few days. [Vendor] came and measured so door can be ordered. 05/17/25 [Vendor] called and the door that came in was damaged, had to reorder. Observations on 05/13/25 at 12:48 PM in Facility A on 05/14/25 at 1:45 PM with Administrator B, revealed the top edge of R64's white plastic bathroom door protector was not attached to the door and protruded an inch away from the door below the doorknob. During an interview on 05/13/25 at 12:48 PM, R64 stated she kept hitting the inside of her left hand on the edge of the bathroom door protector that was protruding below the doorknob. R64 also stated she had not been injured yet but was worried she would be, so she reported it to the Unit Secretary about a month ago and it had not been repaired yet. During an interview on 05/14/25 at 1:37 PM, the Facilities Management Supervisor stated he received a work order about R64's bathroom door protector on 04/16/25, he applied duct tape to the door protector on 04/17/25, and the new door arrived but was damaged, so it had to be reordered on 05/12/25. The Facilities Management Supervisor also stated he did not monitor the interim intervention to ensure it was still in place to prevent it from harming the resident's hand and did not know the duct tape was missing until today. During an interview on 05/14/25 at 3:46 PM, the Unit Secretary stated R64 reported that she was hitting her hand on the protruding plastic door cover when she opened the bathroom door and then she completed a maintenance work order for it. The Unit Secretary also stated that the Facilities Management Supervisor told her that he placed duct tape on the door until the new door arrived, but she did not know who or when it was removed from the door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/15/25 at 5:18 PM, the Administrator stated that the interim intervention of applying the duct tape to the bathroom door protector should have been monitored until the permanent solution, the new door, had arrived to prevent the resident from injury.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, Facility B failed to assess residents for the use of bed rails, review the risks and benefits of bed rail use and obtain informed consent prior to the installation of bed rails for two of seven residents (Resident (R) 28 and R75) reviewed for accidents and hazards out of 31 sampled residents. These failures placed the residents at risk for injury and restraint. Findings include: Review of the facility's policy titled, Bed Safety, dated 08/2019 revealed Our facility shall strive to provide a safe sleeping environment for the resident .1. The resident's sleeping environment shall be assessed by the interdisciplinary team, considering the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and the family .2. To try to prevent deaths/injuries from the beds and related equipment (including the frame, mattress, side rails .) the facility shall promote the following approaches: .e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment .4. The facility's education and training activities will include instruction about risk factors for resident injury due to beds, and strategies for reducing risk factors for injury, including entrapment. 5. If side rails are used, there shall be an interdisciplinary assessment of the resident, consultation with the Attending Physician, and input from the resident and/or legal representative. 6. The staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use .8. Side rails may be used if assessment and consultation with the Attending Physician has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or movie in bed and transfer, and no other reasonable alternatives can be identified. 9. Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with side rails. 1. Review of R28's undated Admitting and Discharge Record, provided by the facility revealed the resident was admitted to the facility on [DATE]. Review of R28's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 03/11/25 revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident was severely cognitively impaired. On 05/14/25, a request to the Social Service Director (SSD) A to assess R28's mental status score. Review of R28's BIMS completed on 05/14/25 by SSDA revealed R28 was assessed to have a score of 14 out of 15 which indicated the resident was cognitively intact. During an observation on 05/14/25 at 11:12 AM, R28 was lying in bed with raised bilateral ¾ bed rails on her bed. The resident stated she could not independently lower the bed rails. During an observation and interview on 05/15/25 at 3:50 PM, Certified Nursing Assistant (CNA)3 observed the resident lying in bed and confirmed the ¾ bed rails on R28's bed were in the raised position. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R75's undated Admitting and Discharge Record, provided by the facility revealed the resident was admitted to the facility on [DATE]. During an observation on 05/14/25 at 10:44 AM, R75 was lying in bed with raised ¾ bilateral bed rails on her bed. During an observation and interview on 05/15/25 at 3:50 PM, CNA3 observed R75 lying in bed with raised ¾ bilateral bed rails on the residents bed. CNA3 confirmed the bed rail use and stated R75 would request both bed rails to be up. During an interview on 05/15/25 at 3:50 PM, Administrator A stated the facility did not obtain consent nor assessed residents prior to bed rail use. During an interview on 05/16/25 at 12:53 PM, Minimum Data Set Coordinator (MDSC) A confirmed there was no documented evidence R28 and R75 were assessed for bed rail use. The MDSCA stated the residents should have been assessed for bed rail use by the admitting nurse. During an interview on 05/16/25 at 1:41 PM, the Director of Nursing (DON)A stated the facility was not aware that residents needed to be assessed or consents obtained before the use of bed rails. During an interview on 05/16/25 at 2:03 PM, Administrator A stated that she was not aware residents needed to be assessed for the use of bed rails or that consent needed to be obtained prior to the use of bed rails.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, review of facility policy, and review of manufacturer's pharmaceutical recommendations, Facility B failed to ensure a medication error rate below five percent. During medication administration for three (Resident (R)10, R51, R108) in the medication administration observation. These failures caused three medication errors out of 25 opportunities for error, or a medication error rate of 12%. These failures had the potential to increase or decrease the effectiveness of these medications. Findings include: Observation during the medication administration observation on 05/15/25 at 11:00AM, Registered Nurse (RN)2 crushed R10's Potassium Chloride Extended Release (ER) 20 milliequivalent (mEq) one tablet, then placed in apple sauce and administered to R10. On 05/15/24 at 11:12AM, crushed R108's ferrous sulfate 300 mg one tablet, then placed in applesauce and administered to R108. On 05/15/25 at 11:31AM, crushed gabapentin, then placed in applesauce and administered to R51. Review of R10's Face Sheet located under the Profile tab in the electronic medical record (EMR) revealed R10 was originally admitted to the facility on [DATE] with the diagnosis of hypokalemia. Review of R10's Physician Orders provided by the facility revealed Potassium Chloride ER, 20MEQ tablet, (medication to treat hypokalemia), oral, one tablet by mouth daily. 2. Review of R51's Face Sheet located under the Profile tab in the EMR revealed R51, was originally admitted to the facility on [DATE] with the diagnosis of iron deficiency anemia. Review of R51's Physician Orders provided by the facility revealed ferrous sulfate 300 milligram (MG) (medication for anemia) one by mouth daily. 3. Review of R108's Face Sheet located under the Profile tab in the EMR revealed R108 was originally admitted to the facility on [DATE] with diagnosis of peripheral neuropathy. Review of R108's Physician Orders provided by the facility revealed gabapentin 100MG capsule (medication to treat peripheral neuropathy) oral, two tablets by mouth, three times daily. During the interview on 05/15/25 at 11:45AM, RN2 was asked why R10, R51 and R108's medication was crushed. RN2 replied, It's easier to get them to take them, when crushed and placed in applesauce. During an interview on 05/15/25 at 2:08PM, RN3 was asked if gabapentin, Potassium Chloride ER, and ferrous sulfate should be crushed. RN3 stated, No, none of those medications are to be crushed. During the interview on 05/15/25 at 2:17PM, Administrator A was asked if gabapentin, Potassium Chloride ER, and ferrous sulfate should be crushed. She stated, They are not to do that [referring to crushing the medications]. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Adverse Effects Medication dated 10/19/2017 indicated, . 3. A 'medication error' is defined as the preparation or administration of drugs or biological which is not in accordance with . manufacturer specifications or accepted professional standards and principles of the professional(s) providing services. Review of the manufacturer's pharmaceutical recommendations for Potassium Chloride ER indicated, . Potassium Chloride ER tablets should not be crushed, chewed, or sucked. Reason: Crushing or altering extended-release tablets can damage the controlled-release mechanism. Risk: This can lead to a rapid and potentially dangerous release of potassium, increasing the risk of hyperkalemia (high potassium levels in the blood), which can have serious side effects, including heart problems . Review of the manufacturer's pharmaceutical recommendations for ferrous sulfate indicated, .Most ferrous sulfate tablets are not meant to be crushed. Reasons not to crush: Enteric-coating: Some tablets may be enteric-coated to protect the stomach lining from irritation or to ensure the medication is released in the intestines. Crushing would destroy this coating . Review of the manufacturer's pharmaceutical recommendations for gabapentin indicated, .Gabapentin tablets should not be crushed, split, or chewed. Swallow whole: The tablets are designed to be swallowed whole with a full glass of water. Potential for altered release: Crushing or splitting may affect the way the medication is released and absorbed, potentially altering its effectiveness or increasing the risk of side effects .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and facility policy review, Facility B failed to ensure kitchen staff thoroughly cleaned and air-dried pans prior to storage. This failure had the potential to increase the risk of foodborne illness and had the potential to affect residents in one of two buildings (Facility B) who received dietary services. Facility failed to ensure that soap was dispensing into the dishwasher after replacing the dish detergent. These failures had the potential to affect all residents in building B, who consumed food from the kitchen. Findings include: Review of the facility's policy titled, Metz Culinary Management Air Drying of Tableware, Utensils, and Pots and Pans dated 01/07/2025, revealed, Purpose: Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Procedures: . i. Equipment and utensils shall be air-dried using racks or storage stands in a self-draining position to permit air to pass around the items enabling them to 'air dry'. iii. At no point can items be stored in a wet condition or 'wet nesting' . 1. During an observation on 05/13/25 at 9:40 AM, the Nutritional Services Director (NSD) confirmed 14 pans, 20 inches by 24 inches by 1 inch deep that had been cleaned and stacked for use were still wet when they were unstacked. The pans were found to have been stacked wet and not allowed to completely air dry before stacking. Interview with the NSD at this time, she stated, The pans should be completely dry before being stacked for use. They should not be wet. They need to be re-washed. 2. On 05/15/25 at 12:01 PM, the following observations in the kitchen of Facility A were identified and verified by the Dietary Manager (DM). Observation of the high-temperature dishwasher during lunch revealed that soap was not coming out of the dispenser into the dishwasher. When the DM took the dishwashing dispenser out of its case, the top of it was clogged and nothing was coming out. A new bottle was placed in the dispenser and the dish soap flowed into the dishwasher. Interview on 05/15/25 at 1:28 PM, the DM revealed The dishwasher buzzes when out of soap. It was replaced the night before at dinner. This has never happened before. The soap was not dispensing. Once replaced for a second time, it now works. Interview on 05/15/25 at 1:49 PM, the Administrator B revealed, My expectation is for the dishwasher to be in working order and the dishes cleaned properly.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and policy review, Facility A failed to ensure garbage was properly disposed of and contained which would affect all the residents and staff in one of two buildings (building B). Findings include: Review of the undated facility's policy, Waste/Garbage Storage, Disposal, Cleaning of Containers, and Pest Prevention revealed, Purpose: prevent contamination and the transmission of disease by pests and rodents . The outside compactor is kept closed and locked at all times except when putting trash into it. The area around the compactor shall be kept clean by all who use it. Observation on 05/13/25 at 10:06 AM, with the Dietary Manager (DM) of the area behind the kitchen in building B where the trash dumpsters were located revealed two dumpsters had the lids open on top and side compartment doors open. There was also trash behind the dumpsters consisting of old chairs. Outside of the kitchen door was a trash can filled with boxes that were to be broken down and six empty 35-gallon plastic oil jugs lying on the ground that were to be disposed of in the dumpsters. Interview on 05/13/25 at 10:06 AM, the DM revealed, The lids on the dumpsters and the side compartment doors should have been closed. There should not be chairs behind the dumpsters. The oil jugs need to go in the dumpsters. Interview on 05/15/25 at 1:49 PM, the Administrator B revealed, My expectation is that the dumpster area needs to be clean, and the doors closed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, interview, and facility policy review, Facility A failed to document a resident's decline, death, and disposition of one of one resident (Resident (R) 141) reviewed for facility death out of a total sample of 31 residents. Findings include: Review of the facility's policy titled Legal Medical Record Policy revised 12/17/20 showed the purpose of the medical record is to provide a record of the patient's health status including observations, measurements, and history/prognosis, and serve as the document describing the healthcare services provided to the patient. Provide a method for clinical communication and care planning among the individual healthcare practitioners serving the patient. Provide supporting documentation for the reimbursement of services provided to the patient. Document and substantiate the patient's clinical care and serve as a key source of data for outcomes research and public health purposes. Serve as a major resource for healthcare practitioner education. Serve to document evidence of quality of care. Serve as the legal business record for a healthcare organization and be used in support of business decision-making. Review of R141's admission Record from the electronic medical record (EMR) Profile tab showed an admission date of 10/10/23 with a medical diagnosis of Alzheimer's disease. Review of R141's EMR Progress Notes from the Progress Note tab dated 04/29/25 revealed that the resident was released to the [NAME] Funeral Home and witnessed by the Hospice nurse. Phone interview on 05/15/25 at 12:40 PM, Licensed Practical Nurse (LPN)2 revealed, I was taking care of R141 who was under Hospice Care. Hospice had been notified that the resident was declining. In the afternoon I gave R141 morphine and when I went back to the room in a couple of hours, she was not breathing. I shook her arm and called her name with no response. I proceeded to get another nurse to verify her passing and then called Hospice. When I went back to the room, R141's son was there, and I informed him of his mother's passing. We waited for the Hospice Nurse to arrive and pronounce the resident's death. I was supposed to document all of the information and with everything going on, I did not document her decline and death. R141 was a Do Not Resuscitate (DNR) code status. Interview on 05/15/25 at 1:59 PM, the Administrator B revealed, I expect our nurses to document and state how a resident was found at the time of death. Documentation is needed to show everything up to the time of death.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interviews and review of facility policy, Facility B failed to maintain a Legionella Water Management Program. This deficient practice has the potential to affect all residents in the facility. Findings include: Review of the facility's policy Legionella Water Management Program, dated 08/20/22, indicated, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella .The purpose of the water management program is to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease .The water management program includes the following elements: A detailed description and diagram of the water system in the facility, including receiving; cold water distribution; heating; hot water distribution; an waste. During an interview on 05/16/25 at 10:15 AM, Engineering (E) stated, We do not have a water diagram for the facility, and we do not have a detailed description of the water system in the facility. I knew that one had to be done, but I had not gotten around to it. Interview on 05/16/25 at 11:09 AM, the Administrator B revealed My expectation is that we follow our policy and CMS guidelines.

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	05/16/2025

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

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, review of Center for Disease Control (CDC) guidance and policy review, the facility failed to monitor and evaluate antibiotic usage for five of seven residents (Resident (R) 117, R100, R47, R119 and R95) reviewed for antibiotic usage out of 31 sampled residents. This failure had the potential to affect residents in the facility safety related to antibiotic usage. Findings include: Review of an undated, untitled CDC document located at http://uprevent.[NAME]. com/2855wp/wp-content/uploads/2018/01/nh-hac_mcgreercriteriarevcomp_2012-1.pdf; revealed, The Core Elements of Antibiotic Stewardship for Nursing Homes indicated, .Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority .Antibiotic stewardship refers to a set of commitments and actions designed to 'optimize the treatment of infections while reducing the adverse events associated with antibiotic use' .CDC also recommends that all nursing homes take steps to improve antibiotic prescribing practices and reduce inappropriate use .Nursing homes monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice changes and track the impact of new interventions. Data on adherence to antibiotic prescribing policies and antibiotic use are shared with clinicians and nurses to maintain awareness about the progress being made in antibiotic stewardship. Clinician response to antibiotic use feedback (e.g., acceptance) may help determine whether feedback is effective in changing prescribing behaviors. Below are examples of antibiotic use and outcome measures .Process measures: Tracking how and why antibiotics are prescribed .Antibiotic use measures . Tracking how often and how many antibiotics are prescribed .Antibiotic outcome measures .Tracking the adverse outcomes . Review of the facility's policy titled, Antibiotic Stewardship dated 03/2019 revealed, Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program . The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents . Changes to antibiotic orders based on culture and sensitivity will be reviewed by the facility infection preventionist or a pharmacist or designee .Lab results will be communicated to the prescriber as soon as available to determine if antibiotic is appropriate . 1. Review of R117's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R117 was admitted to the facility on [DATE]. On 02/05/25 a urine analysis (UA) and culture and sensitivity (C&S) was completed and the physician started R117 on Amoxicillin (antibiotic medication) that did not meet McGeer Criteria, and the C&S was negative. 2. Review of R100's admission Record located under the Profile tab of the EMR revealed R100 was admitted to the facility on [DATE]. On 03/28/25, UA and C&S were ordered and came back as contaminated but was not repeated. Bactrim (antibiotic medication) was started by the physician and did not meet McGeer Criteria. 3. Review of R47's admission Record located under the Profile tab of the EMR revealed R47 was admitted to the facility on [DATE]. On 03/19/25, R47 was started on an antibiotic for respiratory issues did not meet McGeer's Criteria and no testing was completed such as chest x-ray. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Review of R119's admission Record located under the Profile tab of the EMR revealed R119 was admitted to the facility on [DATE]. On 04/22/25 a urine analysis (UA) and culture and sensitivity (C&S) was completed and the physician started R119 on Cefdinir (antibiotic medication) that did not meet McGeer Criteria, and the C&S was negative. 5. Review of R95's admission Record located under the Profile tab of the EMR revealed R95 was admitted to the facility on [DATE]. On 04/23/25 a urine analysis (UA) and culture and sensitivity (C&S) was completed and the physician started R95 on an antibiotic that did not meet McGeer Criteria, and the C&S was negative. Interview with the Infection Preventionist Building A (IPBA) on 05/16/25 at 12:07 PM, the IPBA revealed, I do not question the physician about antibiotics. I know that antibiotics are started before cultures are back. I need to follow McGeer's Criteria and educate staff. Interview on 05/16/25 at 1:40 PM , the Medical Director (MD) revealed, I guess we need work in the area of Antibiotic Stewardship. When the MD was asked if he understood the reason why antibiotic stewardship was started, he stated I really haven't thought about it. During an interview on 05/16/25 at 2:12 PM, the Administrator revealed We have to follow McGeer's Criteria and track antibiotic usage. We need to follow policies and procedures for antibiotic stewardship.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interviews, Facility B failed to maintain staff documentation of current COVID-19 vaccination status. This failure had the potential to affect all 132 residents in the facility and all staff. Findings include: Interview with the Director of Nursing (DON) B on 05/16/25 at 12:18 PM revealed We do not have current COVID-19 documentation for our staff members either immunized or not. I did not know that we had to have that documentation. During an interview on 05/16/25 at 12:33 PM, the Administrator revealed, We do not have current vaccination status for COVID-19 for our staff. We provide education, but do not keep staff status.