STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115776	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archbold Living Cairo	1057 5th Street SE Cairo, GA 39828

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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 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 observation, staff interviews, and review of the facility policy titled, Cleaning and Disinfection, Storage, Maintenance, Repair of Replacement of the Accu-Chek Inform II Meter, the facility failed to develop and implement a policy for Legionella with procedures to be put in place for the prevention and spread of Legionella. This had the potential to affect all 71 residents in the facility. In addition, the facility failed to disinfect a blood glucose monitor in between checking blood glucose levels (accuchecks) for three Residents (R) (R12, R58, and R66) of three residents observed during blood glucose monitoring out of a total sample of 22 residents. Findings include:Review of the facility policy titled, Cleaning and Disinfection, Storage, Maintenance, Repair of Replacement of the Accu-Chek Inform II Meter dated 1/2024 revealed, In accordance with CDC [Centers for Disease Control and Prevention] and CMS [Centers for Medicare and Medicaid] guidelines and in order to help decrease and prevent the spread of infection between patients/residents, the Accu-Chek Inform II Meter must be CLEANED and DISINFECTED after each patient/resident use and whenever visibly soiled using one of the approved disinfected products listed below: Acceptable active ingredients and products for cleaning and disinfecting are Clorox Germicidal Wipes (Environmental Protection Agency (EPA) rcl. no.67679-L2) pre-moistened disinfecting cloths (active ingredient 1% (or less) solution of sodium hypochlorite in water) Cleaners and disinfectants were validated separately and only one cleaning/disinfecting solution should be used on the device as the effect of using more than one cleaning/disinfectant interchangeably has not been evaluated. EPA approved Clorox Healthcare Bleach Germicidal Wipes are a One-Step Disinfectant Cleaner (cleans and disinfects with one wipe) designed for general cleaning and disinfecting of equipment. However, a two-step process may be required if gross debris, blood, or body fluids are visible. This involves wiping/removing the debris with one or more Germicidal Wipes first and then disinfecting with an additional wipe and letting it remain visibly wet for the recommended contact time of THREE (3) minute to kill bacteria and viruses.1. Review of the facility records revealed there was no evidence of a facility water system plan or Legionella policy in place. During an interview on 8/7/2025 at 10:48 am, the Engineer Director (ENG) was asked for the policy for Legionella. He stated he had nothing to provide regarding the facility water system and the facility did not have a policy for Legionella. 2. During an observation on 8/5/2025 at 3:46 pm, Licensed Practical Nurse (LPN) 1 entered R12's room to complete an accu check. After completing the accu check she placed the glucose monitor on the medication cart without disinfecting it. At 4:05 pm LPN1 used the same glucose monitor without disinfecting it and entered R58's room to perform an accu check. After taking the accu check she placed the glucose monitor on the medication cart and did not disinfect it. At 4:23 pm LPN1 picked up the same glucose monitor and went in R66's room to perform an accu check without disinfecting it. She completed the accu check and carried the glucose monitor and placed it in the medication cart without disinfecting it. During an interview on 8/5/2025 at 4:50 pm LPN1 confirmed she did not disinfect the glucose monitor in between use of the three residents and should have.The facility confirmed none of the three residents (R12, R58, and R66) had any blood borne pathogens/diseases.

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 staff interview, record review, and review of the facility's policy titled Resident Assessments, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were transmitted for six out of 22 sampled Residents (R) (R19, R23, R49, R65, R66, and R76). This failure had the potential to not ensure payment and lack of quality measures. In addition, the potential for a lack of adequate care planning for resident care needs.Findings include:Review of the facility's policy titled Resident Assessments revealed A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments - conducted for all residents il the facility: Quarterly Assessment - Conducted not less frequently than three (3) months following the most recent OBRA assessment of any type. Annual Assessment (Comprehensive) - Conducted not less than once every twelve (12) months.1. Review of R19's quarterly MDS with an Assessment Reference Date (ARD) of 6/23/2025, located in the electronic medical record (EMR) under the MDS tab revealed R19 admitted to the facility on [DATE] and did have a completed quarterly MDS assessment, however it had not been transmitted.2. Review of R23's quarterly MDS with an ARD of 6/24/2025, located in the EMR under the MDS tab revealed R23 did have a completed quarterly MDS assessment, however it had not been transmitted.3. Review of R49's quarterly MDS with an ARD of 6/20/2025, located in the EMR under the MDS tab revealed R49 did have a completed quarterly MDS assessment, however it had not been transmitted.4. Review of R65's quarterly MDS with an ARD of 6/18/2025, located in the EMR under the MDS tab revealed R65 did have a completed quarterly MDS assessment, however it had not been transmitted.5. Review of R66's quarterly MDS with an ARD of 6/19/2025, located in the EMR under the MDS tab revealed R66 did have a completed quarterly MDS assessment, however it had not been transmitted.6. Review of R76's quarterly MDS with an ARD of 7/4/2025, located in the EMR under the MDS tab revealed R76 did have a completed quarterly MDS, however, it had not been transmitted.During an interview on 8/7/2025 at 12:53 pm, the MDS Coordinator (MDSC) stated that she had been overwhelmed with the number of assessments and had been doing the best she could to keep everything caught up. She confirmed the six residents did not have their quarterly MDS assessments transmitted.During an interview on 8/7/2025 at 2:30 pm, the Director of Nursing (DON) stated that the facility was aware of the issue with the number of MDSs not being completed or transmitted timely. The DON confirmed the six residents did not have their quarterly MDS assessments transmitted.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled, Administering Medications, the facility failed to ensure three of eight Residents (R) (R31, R65, and R57) reviewed for medication administration out of a sample of 22 residents received medications from the pharmacy as ordered by the physician for administration. This failure had the potential to cause residents to have unmet care needs.Findings include: Review of the facility's policy titled, Administering Medications, dated 10/19/2017 revealed, Medications shall be administered in a safe and timely manner, and as prescribed.Medications must be administered in accordance with the orders. 1.Review of R31's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed the resident was originally admitted to the facility with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction (stroke), and diabetes mellitus type one. diabetes mellitus type one.Review of R31's EMR under the Physician Orders tab revealed an order dated 1/15/202025 for Cholestyramine Light four gram/dose powder, one packet to enteral tube twice a day at 6:00 am and 5:00 pm for hyperlipidemia. Review of R31's EMR under the Medication Administration Record (MAR) tab, revealed the medication was not administered on 7/18/2025, 7/19/2025, 7/27/2025, 7/28/2025 or 7/29/2025 at 5:00 pm. The Nurse Notes located in the EMR under the Nurses Notes tab, revealed that on 7/27/2025 and 7/28/2025 the medication was unavailable for the 5:00 pm dose. There was no documentation why the medication was not administered on 7/18/2025, 7/19/2025, or 7/29/2025. Review of R31's August 202025 MAR located in the EMR under the MAR tab revealed the medication was not administered on 8/1/2025, 8/3/2025, and 8/5/2025 at 6:00 am due to it not being available.Review of R31's EMR under the Physician Orders tab revealed an order dated 1/15/2025 for Insulin NPH (Human) (Isophane) 100 unit/ml (milliliters) suspension. Subcutaneous five units sub-q twice a day at 8:00 am and 8:00 pm, for diabetes mellitus. Review of R31's July 202025 MAR located in the EMR under the MAR tab revealed the insulin was not administered on 7/9/2025 at 8:00 am and 8:00 pm, on 7/10/2025 at 8:00 am, or on 7/11/2025 at 8:00 am. The Nurse's Notes indicated the medication was unavailable or they were waiting on pharmacy.Review of R31's Physician Orders located in the EMR under the Physician's Orders tab revealed an order dated 1/30/2025 for Banatrol plus (banana flakes) one packet enteral tube twice a day at 8:00 am and 12:00 pm, for loose stools. Review of R31's MAR under the MAR tab in the EMR, revealed the Banatrol was not administered on 7/31/2025 at 8:00 am, on 7/23/2025, 7/29/2025, 7/31/2025 at 12:00 pm, on 8/1/2025, 8/2/2025, and 8/3/2025 for both doses. The Banatrol was documented as not being available on all the dates except for 7/23/2025 and 7/29/2025, as there was no reason was given. 2. Review of R65's Face Sheet located in the EMR under the Face Sheet tab revealed the resident was originally admitted to the facility on [DATE]. Review of R65's EMR under the Physician Orders tab revealed an order dated 5/14/2025 for Olanzapine 5 mg (milligram) one table by mouth at bedtime 9:00 pm, for mood disorder. Review of R65's EMR under the MAR, revealed on the August 202025 MAR that the Olanzapine was not administered on 8/4/2025 and 8/5/2025 due to the medication not being available.Review of R65's EMR under the Physician Orders tab revealed an order dated 4/15/2024 for Famotidine 40 mg , by mouth twice daily at 9:00 am and 9:00 pm, for heartburn. Review of R65's EMR under the MAR tab, revealed the medication was not administered on 6/25/2025, 6/26/2025, and 6/27/2025 at 9:00 pm due to it not being available. The August 2025 MAR revealed the medication was not given on 8/3/2025 at 9:00 am due to it not being available.Review of R65's EMR under the Physician Orders tab revealed an order dated 5/14/2025 for Gabapentin 300 mg capsule one by mouth three times a day at 8:00 am, 3:00 pm, and 11:00 pm, for neuropathic pain. Review of R65's EMR under the MAR, revealed on the July 202025 MAR that the Gabapentin was not administered on 7/8/2025 at 8:00 am and 11:00 pm, or on 7/9/2025 at 8:00 am and 3:00 pm due to it not being available.3. Review of R57's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Face Sheet located in the EMR under the Face Sheet tab revealed the resident was originally admitted with a diagnoses that included but not limited to chronic kidney disease stage three, hypertension, and diabetes mellitus type two.Review of R57's EMR under the Physician Orders tab revealed an order dated 6/25/2025 for Hydralazine 50 mg one half tablet by mouth twice a day at 9:00 am and 9:00 pm, for hypertension. Review of R57's EMR under the MAR tab revealed the Hydralazine was not administered on 7/24/2025 at 9:00 am, on 7/31/2025 at 9:00 pm, on 8/4/2025, 8/5/2025, and 8/6/2025 at 9:00 pm due to it not being available.Review of R57's EMR under the Physician Orders tab revealed an order dated 6/9/2025 for Atorvastatin Calcium 40 mg, one tablet daily at 9:00 am, for hyperlipidemia. Review of R57's EMR under the MAR tab revealed the Atorvastatin was not administered on 7/3/2025, 7/5/2025, 7/6/2025, 7/7/2025, 7/8/2025, and 7/9/2025 due to the medication not being available. Review of R57's EMR under the Physician Orders tab revealed an order dated 6/9/2025 for Dapagliflozin Propanediol 10 mg one tablet by mouth daily at 9:00 am, for diabetes mellitus type two. Review of R57's EMR under the MAR tab revealed on 7/2/2025, 7/3/2025, 7/7/2025, 7/8/2025, 7/9/2025, and 7/24/2025 the medication was not administered due it not being unavailable.During an interview on 8/7/2025 at 9:30 am, Licensed Practical Nurse (LPN) 3 stated if a medication was not available at the time of administration the nurse would click the button in the EMR to reorder the medication and then document not available. She confirmed the above findings for all three residents (R31, R65, and R57) that medications were not being administered due to most of them not being available. LPN3 confirmed that the facility had been struggling with pharmacy delay issues.During an interview on 8/7/2025 at 10:03 am, the Clinical Coordinator (CC) confirmed that pharmacy orders and deliveries were a current problem at the facility. She said that the pharmacy only gave them enough medication for fourteen days. She said this was for all physician orders. She said the EDK (emergency kit) only had certain medications in it and it was limited. However, she said the nurses should go and look to see if the medication they need is in the EDK, and if so, they should pull the medication.During an interview on 8/7/2025 at 11:00 am, the Director of Nursing (DON) stated that the pharmacy used by the facility provided for a fourteen-day supply at a time and confirmed the fourteen-day refill cycle had been a constant frustration. She confirmed the facility used one EDK which she said usually covered their needs, but was limited. The DON confirmed that the facility did have a medication pharmacy concern.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy titled Discharges, the facility failed to ensure that a transfer agreement was provided to one out of 22 sampled Residents (R) (R13) and the resident's representative (RR) reviewed for hospital transfers. This failure had the potential for R13 and the RR not to have the knowledge of where and why a resident was transferred and/or how to appeal the transfer.Findings include:Review of the facility's policy titled Discharges dated 3/30/2023 revealed the policy did not address providing a written transfer agreement to the resident or RR.Review of R13's undated admission and Discharge Record located under the Resident tab in the electronic medical record (EMR) revealed the resident was admitted to the facility on [DATE].Review of R13's Progress Note dated 4/21/2025 at 1:13 pm, located in the EMR under the Resident tab revealed R13 was transferred to the emergency department by ambulance at 1:05 pm for cardiac/blood symptoms: hypotension, gastrointestinal/genitourinary symptoms: abdominal/pelvic pain, nausea, or vomiting. The resident did return to the facility. However, there was no evidence that the facility provided a written transfer agreement to the resident or RR.During an interview on 8/5/2025 at 2:22 pm, the Director of Nursing (DON) confirmed there was no written transfer agreement provided to R13 and/or RR. She said the facility notifies the RR by telephone of a change in condition that would cause the resident to be transferred to the hospital and the nurse will chart when the call was made.During an interview on 8/6/2025 at 1:00 pm the Business Office Manager (BOM) stated that she sends the discharge transfers to the ombudsman every month, however, confirmed that she did not provide a written transfer agreement to the resident and/or RR.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, and review of the facility's policy titled Resident Assessments, the facility failed to ensure the comprehensive assessments was completed for one out of 22 sampled Residents (R) (R42). This failure had the potential to lead to a lack of adequate care planning for R42's care needs.Findings include:Review of the facility's policy titled Resident Assessments revealed A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments - conducted for all residents il the facility: (l) Initial Assessment (Comprehensive) - Conducted within fourteen (14) days of the resident's admission to the facility.Review of R42's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/4/2025, located in the electronic medical record (EMR) under the MDS tab revealed R42 admitted to the facility on [DATE]. The comprehensive assessment was started; however, it was not completed.During an interview on 8/7/2025 at 12:53 pm, the MDS Coordinator (MDSC) stated that she had been overwhelmed with the number of assessments and had been doing the best she could to keep everything caught up. She confirmed R42's admission comprehensive MDS was started, however it had not been completed.During an interview on 8/7/2025 at 2:30 pm, the Director of Nursing (DON) stated that the facility was aware of the issue with the number MDSs not being completed or submitted timely. The DON also stated that when the facility opened a little over a year ago the number of skilled nursing residents increased significantly and the current MDS nurse could not keep up with the assessments. The DON confirmed R42's admission MDS had been started, however it had not been completed.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. Based on staff interview, record review, and review of the facility's policy titled Resident Assessments, the facility failed to ensure the quarterly Minimum Data Set(MDS) assessments were completed for three out of 22 sampled Residents (R) (R56, R60, and R84). This failure had the potential to lead to a lack of adequate care planning for resident care needs based on the quarterly assessments.Findings include:Review of the facility's policy titled Resident Assessments revealed that A comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPSrequirements. The Resident Assessment Coordinator is responsible for ensuring that the Interdisciplinary Team conducts timely and appropriate resident assessments and reviews according to the following requirements: a. OBRA required assessments - conducted for all residents il the facility: Quarterly Assessment - Conducted not less frequently than three (3) months following the most recent OBRA assessment of any type. Annual Assessment (Comprehensive) - Conducted not less than once every twelve (12) months.1. Review of R56's quarterly MDS with an Assessment Reference Date (ARD) of 6/25/2025, located in the electronic medical record (EMR) under the MDS tab revealed a quarterly assessment had been started for R56, however it was not completed.2. Review of R60's quarterly MDS with an ARD of 7/3/2025, located in the EMR under the MDS tab revealed a quarterly assessment had been started for R60, however it was not completed.3. Review of R84's quarterly MDS with an ARD of 7/4/2025, located in the EMR under the MDS tab revealed a quarterly assessment had been started for R84, however it was not completed.During an interview on 8/7/2025 at 12:53 pm, the MDS Coordinator (MDSC) stated that she had been overwhelmed with the number of assessments and has been doing the best she can to keep everything caught up. She confirmed R56, R60, and R84 had quarterly MDS assessments started, however, they were not completed.During an interview on 8/7/2025 at 2:30 pm the Director of Nursing (DON) stated that the facility was aware of the issue with number MDSs not being completed or submitted timely. The DON also stated that when the facility opened a little over a year ago the number of skilled nursing residents increased significantly and the current MDS nurse could not keep up with the assessments.

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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 staff interview, record review, and review of the facility's policy titled, Comprehensive Care Plans, the facility failed to ensure the comprehensive care plan included the diagnosis of schizophrenia and use of an antipsychotic medication for one out of 22 sampled Residents (R) (R8) reviewed for care planning. The failure had the potential for the resident's care needs to not be met.Findings include:Review of the facility's policy titled, Comprehensive Care Plans, indicated .develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the residents comprehensive assessment.Review of R8's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/7/2025 located in the electronic medical record (EMR) under the MDS tab, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The MDS revealed the resident was admitted on [DATE] with a diagnosis of schizophrenia.Review of R8's Care Plan located in the EMR under the Care Plan tab revealed a comprehensive care plan dated 12/16/2024, however there was no evidence of a care plan for the resident's diagnosis of schizophrenia or the use of an antipsychotic medication.During an interview on 8/7/2025 at 12:40 pm, the MDS Coordinator (MDSC) stated that a resident with the diagnosis of schizophrenia that was currently taking an antipsychotic should have a care plan so that staff know the needs of that resident. She confirmed R8 did not have a care plan for the diagnosis of schizophrenia.During an interview on 8/7/2025 at 1:15 pm, the Director of Nursing (DON) stated that schizophrenia should have been on R8's care plan to let the staff know that R8 was being monitored for behaviors and adverse reactions to an antipsychotic medication. The DON confirmed R8 did not have a care plan to address the diagnosis of schizophrenia.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy titled, Enteral Nutrition, the facility failed to ensure a resident who received enteral nutrition via a gastrostomy tube (g-tube) received the ordered amount of flushes during the g-tube administration for one out of three Residents (R) (R31) reviewed for tube feeding out of 22 sampled residents. This had the potential to affect the resident's hydration status.Findings include:Review of the facility's policy titled, Enteral Nutrition, dated 8/2019 revealed, Adequate nutritional support through enteral feeding will be provided to residents as ordered . estimate calorie, protein, nutrient and fluid needs.calculate fluids to be provided (beyond free fluids in formula).Review of R31's Face Sheet located in the electronic medical record (EMR) under the Face Sheet tab revealed the resident was admitted to the facility on [DATE].Review of R31's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 5/28/2025 located in the MDS tab of the EMR revealed she used a feeding tube.Review of R31's Care Plan dated 5/21/2025, located in the EMR under the Care Plan tab revealed R31 Received Nutrition via tube feeding . having a gastrostomy tube.Care plan approaches included . provide me with the tube feeding formula I need.follow my diet plan. The resident's care plan goal included to, .stay well hydrated.maintain my weight.Review of R31's Physician Orders located in the EMR under the Orders tab revealed an order dated 6/11/2025 for Tube Feeding [Osmolite 1.2 Cal (calorie)] Nutritional Supplements, Liquid via Enteral tube at 90 ml/hr (milliliters per hour) for 18 hours with water flush 220 ml (milliliters) every four hours. The tube feeding began at 10:00 am and ended at 4:00 am each 24-hour period.During observations of R31 on 8/4/2025 at 11:17 am, and on 8/6/2025 at 11:33 am the resident's tube feeding pump was set and running at 90 ml/hr with a 240 ml flush every four hours. This indicated the resident was receiving an extra 20 ml of flushes every four hours during the 18 hours of tube feeding.During an interview on 8/6/2025 at 11:35 am, Licensed Practical Nurse (LPN) 4 was asked what the physician order for R31's feeding tube was. She verbalized that the resident was on 90 ml with a water flush every four hours at 240 ml. Upon review of the EMR, LPN4 said that it looked like the resident now had an order for 220 ml flush rate every four hours. Upon observation of R31's feeding tube pump with LPN4, she confirmed it was currently set at the wrong flush rate and changed it.During an interview on 8/7/2025 at 10:03 am, the Clinical Coordinator confirmed R31 required the use of a tube feed. She stated that nurses should be checking the physician order for accuracy of administration every shift.During an interview on 8/7/2025 at 11:00 am, the Director of Nursing (DON) said that LPN4 had informed her about R31's feeding tube had been running at the incorrect flush rate. She stated that she expected the facility nurses to verify the physician order in the EMR and the setting on the tube feeding pump was the same and running correctly before administration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115776	A. Building B. Wing	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archbold Living Cairo	1057 5th Street SE Cairo, GA 39828

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidance, review of the McGreer criteria for antibiotic use for urinary tract infections (UTIs), and review of the facility policy titled, Infection Prevent and Control Program, the facility failed to maintain a functional Antibiotic Stewardship Program that ensured an antibiotic prescribed and administered met the McGreer criteria and CDC guidance for one of one Residents (R) (R80) reviewed for antibiotic stewardship out of a total sample of 22 residents. This had the potential for the development of antibiotic-resistance organisms and side effects related to the use of an antibiotic.Findings include:Review of the McGreer criteria located at https://hqin.org/resource/revised-mcgeer-criteria-for-infection-surveillance-checklist/ the criteria for prescribing an antibiotic for a UTI without an indwelling catheter revealed at least one of the following signs or symptoms must be met, acute dysuria (discomfort when urinating), fever or leukocytosis (high level of white blood cells indicating infection), suprapubic pain, gross hematuria (blood in the urine), new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency. If no fever or leukocytosis, then two of the following must be met, suprapubic pain, gross hematuria, new or marked increase in incontinence, new or marked increase in urgency, new or marked increase in frequency and at least one of the following, microbiologic criteria greater than 105 cfu/mL (colony-forming units per milliliter/a common threshold used to indicate the presence of a significant bacterial infection), of no more than two species of organisms in a voided urine sample, or greater than 102 cfu/mL of any organism(s) in a specimen collected.Review of an undated, untitled CDC document located at https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html 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. 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 policy titled, Infection Prevent and Control Program dated 8/2019 revealed . 8. Antibiotic Stewardship, a. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities. b. Medical criteria and standardized definitions of infections are used to help recognize and manage infections. c. Antibiotic usage is evaluated and practitioners are provided feedback on reviews. Review of R80's admission Record, located under the Face Sheet tab of the electronic medical record (EMR), revealed R80 was admitted to the facility on [DATE] with diagnoses that included neurogenic bladder, urinary retention, and recurrent UTIs.Review of R80's Progress Notes dated 7/18/2025 located in the EMR under the Progress Notes tab revealed the resident had cloudy urine with a foul odor, and that the resident was prone to UTIs. An order was received for a Urinalysis, Culture, and Sensitivity (UA/CS).Review of R80's Physician Orders, located under the Orders tab of the EMR, revealed a physician's order, dated 7/18/2025 for Sulfamethoxazole-Trimethoprim (Bactrim/Antibiotic) 400 milligrams (mg)-80 mg tablet to be given twice a day for seven days with a start date of 7/18/2025 for a UTI. There was no evidence that the resident had a fever, suprapubic pain, blood in the urine, or an increase in incontinence or urgency. The antibiotic was ordered and started before the results of the UA/CS were received.Review of (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R80's Lab Results Report dated 7/21/2025 and provided by the facility revealed the UA collected on 7/18/2025 showed a possible contamination and another UA/CS was collected on 7/21/2025. The final report was issued on 7/24/2025 at 8:51 am for microbiology sensitivity.Review of R80's Progress Notes, dated 7/24/2025, revealed the UA/CS results from the second UA/CS were called into the PCP (primary care physician), and the antibiotic was changed to Zosyn 3.375g [grams] IV [intravenously] every eight hours for 10 days for UTI.During an interview on 8/7/2025 at 11:21 am, the Infection Preventionist (IP) said that nurses would call the physician for a UA depending on a resident's symptoms by either calling or leaving a message with the physician's call system. She stated that the physician would determine whether or not to order a CS to the UA. The IP confirmed the facility used the McGreer criteria when completing a UA/CS and ordering antibiotics for residents when a UTI was suspected or confirmed. She said R80 was ordered an antibiotic on the day the first UA/CS was collected on 7/18/2025. When the report came back on 7/21/2025 it was suspected there was contamination, so a new urine had to be collected. She confirmed however the antibiotic was already started on 7/18/2025. The new UA/CS was collected on 7/21/2025 with the results received on 7/24/2025. That was when it was discovered the wrong antibiotic was given based on the new UA/CS. The IP further revealed that this happens often with the physician ordering antibiotics before they have the UA/CS back or even if they don't meet the McGreer criteria for a UTI.