

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALC000117	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/12/2025
NAME OF PROVIDER OR SUPPLIER BUCKINGHAM SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5450 ABERCORN STREET SAVANNAH, GA 31405	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
{0000}	Initial Comments. >>>> The purpose of this visit was to investigate intake #5000564. The investigation began on 9/29/2025 and ended on 10/1/2025. An onsite visit was made on 10/1/2025.		
{1000} SS= D	111-8-63-.10(1) Community Accountability. The records required by these rules and other records maintained in the normal course of the business of the community must be available for inspection and review by properly identified representatives of the Department. This REQUIREMENT is not met as evidenced by: >>>> Based on record review and interviews, the facility failed to make the call log records available for inspection. Findings include: A review of the incident report (IR) showed AB requested for a copy of the call log record because Resident #1 told a family member that he/she had been pressing the call buttons because he/she fell. The IR showed Staff A told family members that this record existed, but the family member neither received nor saw such records.		

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{2409} SS= D	During a phone interview on 9/29/2025 at approximately 10:24 a.m., AB stated he/she requested for this document including the video footage to check if staff responded in a timely manner whenever Resident #1 pressed the call button. During an onsite visit on 10/1/2025 at approximately 1:24 p.m., the Department representative (DR) requested the facility for the same documents that pertained particularly on Resident #1's call logs. Staff A and Staff B assured the DR that they have the record, but so-called report was not received by the end of the visit. 111-8-63-.24(2)(i) Residents' Files. Each resident's file must include the following information: ... (i) health information including all health appraisals, diagnoses, prescribed diets, medications, and physician's instructions; ... This REQUIREMENT is not met as evidenced by: >>>> Based on record review and interviews, the facility failed to include in each resident's file the health information including all health appraisals, among others, for 1 of 3 sampled residents (Resident #1). Findings include A review of an incident report (IR) showed an allegation that Resident #1 sustained a wound of unknown origin. The complainant could not recall the exact date of the incident.		

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	A review of the compilations of facility-prepared IRs for Resident #1 showed Resident #1 had one (1) unwitnessed fall on 2/14/2025 when staff found him/her lying on the floor in his/her bedroom at approximately 7:00 a.m. Resident #1 was conscious and able to communicate with staff that his/her right arm and left leg hurt, but he/she did not want to go to the Emergency Room. No other injuries were reported. On 3/3/2025, Resident #1 fell while a staff member was helping him/her to relocate in the wheelchair at about 9:00 a.m. Resident #1 denied having pain despite bruising on right leg and right arm. On 8/9/2023 at about 1:45 a.m., a staff member was taking Resident #1 to the bathroom in his/her wheelchair. Resident #1 rubbed his/her arm against a table, and he/she had a skin tear. A staff member cleaned up the skin tear and bandaged the affected area in his/her arm. A handwritten note under the 8/9/2023 IR showed Resident #1 was on a daily wound care by home health. A review of the file for Resident #1, admitted [REDACTED], showed diagnoses of debility, upper respiratory infection (URI), atrial fibrillation (AFIB), hypertension (HTN), gastroesophageal reflux disease (GERD), chronic kidney disease (CKD) stage 3, metabolic acidosis, and left foot pain. However, no home health appraisal was in the file. During a phone interview on 9/29/2025 at approximately 10:24 a.m., AB stated that Staff A stated the wound was a minor one, but it took about a year to heal this wound that Resident #1 sustained on his/her left leg. AB stated the origin of the wound remained unknown until family members moved Resident #1 out of the		

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	facility on 6/7/2025. AB stated Resident #1 was seen by home health for wound care. During an interview on 10/1/2025 at approximately 2:06 p.m., Staff A stated that Resident #1 had a wound that had been taken care of by home health. Staff A stated he/she did not think that this occurred in 2023, but he/she recalled Resident #1 having bruises on left leg and right arm when he/she fell in his/her bedroom on 2/14/2025. Staff A stated that Resident #1 expressed pain, but he/she did not want to be transported to the Emergency Department. The Department representative requested Home Health appraisal for Resident #1 at the time of visit, but no record was received.		