STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115110	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buckhead Center for Nursing and Healing	54 Peachtree Park Drive N.E. Atlanta, GA 30309

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to ensure the call light was accessible for one of 33 residents (Resident (R) 99) observed in the Initial Pool. This failure placed R99 at risk of falling and injuries or distress when he could not access the call light to alert staff of an emergency or unmet needs.Findings include:Review of the facility's undated policy titled, Answering the Call Light revealed, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.Review of R99's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed he was admitted with diagnoses including but not limited to stroke affecting left non-dominant side, tracheostomy status, and gastrostomy status.Review of R99's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/8/2025, located under the MDS tab of the EMR, revealed R99's Brief Interview for Mental Status (BIMS), indicating he was rarely/never understood. R99 was dependent on staff for all the activity daily livings (ADLs) and had range of motion impairment on one side of upper and lower extremities.Review of R99's Care Plan, dated 9/25/2025 and located under the Care Plan tab of the EMR, included a care plan for The resident has an ADL self-care performance deficit revised on 6/14/2025, documented Encourage the resident to use bell to call for assistance.Review of R99's second care plan for The resident is at risk for fall r/t [related to] to impaired mobility, poor safety awareness, revised on 10/29/2024, indicated,-Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.During observations in R99's room on 9/22/2025 at 9:05 AM and 9/22/2025 at 10:16 AM, R99 was lying in bed in his room and receiving tube feeding. R99's bed was against his right-side wall, and he was on a low bed with a deep blue colored floormat to his left side of floor for safety and fall protection. His call pad/light was resting on his oxygen machine on the top of his bedside table, which was located behind his bed's headboard and obscured by a curtain that he could not reach. Observed R99's call pad was in the same location, resting on his oxygen machine on the top of his bedside table, which was located behind his bed's headboard and obscured by a curtain that he could not reach from 9/22/2025 at 9:06 AM throughout 9/22/2025 at 4:20 PMDuring an observation in R99's room on 9/23/2025 at 9:00 AM, R99's bed was against his right-side wall, and he was on a low bed with the floormat to his left side of floor. His call pad/light was on the top of left corner of his bed, which he could not reach. When asked, R99's roommate, R72, stated that no staff came to pick up his call light from the floor and placed it on his bed until last night around 6:00 PM. R72 further stated that the same staff also placed R99's call pad at the current location, to the top left corner of R99's bed.During several observations R99's call pad was observed in the same location on the top of left corner of his bed, which he could not reach for three different days as follows:9/22/2025 at 10:12 AM, from 4:00 PM to 4:40 PM. 9/23/2025 from 9:43 AM to 9:46 AM, at 11:24 AM, and 2:29 PM.9/24/2025 from 8:00 AM to 8:04 AM, at 8:29 AM, 8:55 AM, and from 11:06 AM to 11:17 AM.9/25/2025 at 4:27 AM and 7:00 AM.During an observation on 9/25/2025 at 7:01 AM, verified with Licensed Practical Nurse (LPN)4 in R99's room, when R99 was asked to reach and press the call pad, the resident's face looked confused and could not speak due to the tracheostomy. R99 shook his head to express he could not. When R99 was asked to raise any of his arms, he did not and shook his head to communicate he could not. LPN4 said she should put the call pad under R99's head or body.On 9/25/2025 at 3:05 PM, the Director of Nursing (DON) stated that R99 could not press the call pad by hand, and the staff should attach the call pad to his head to function properly.

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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. Based on observations, resident, resident responsible party, and staff interviews, and record review, the facility failed to provide adequate Activities of Daily Living (ADL) care for one (R128) out of 33 sampled residents. This failure had the potential to negatively affect R128.Findings include:Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated April 2024 indicated, Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent.neglect.Definitions.Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Policy Explanation and Compliance Guidelines:The facility will develop and implement written policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property; b. Establish policies and procedures to investigate any such allegations; and c. Include training for new and existing staff on activities that constitute.neglect.reporting procedures, and dementia management and resident abuse prevention.Review of the facility's policy titled, Activities of Daily Living undated indicated, Policy Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. Activities of daily living (ADL's) include: Hygiene - bathing,.grooming.ADL care is documented every shift by the nursing assistant on an ADL flow record or in PointClickCare (PCC).Review of Resident (R) 128's Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R128 was admitted to the facility with the diagnoses of but not limited to hemiparesis and hemiplegia, major depressive disorder, low vision in left eye, and dementia.Review of R128's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 6/24/2025 (quarterly), located under the RAI tab indicated R10 was supervision for eating; substantial/maximum assistance for bed mobility; dependent for oral hygiene; dressing, toileting hygiene, and bathing. The MDS indicated a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicated R128 was moderately cognitively impaired. Review of R128's EMR under the Progress Notes tab dated 9/9/2025 indicated, SSA (Social Service Assistant) conducted care plan meeting with resident's daughter (RP128).Daughter voiced concerns and she was informed that SS (Social Services) will follow up as needed on resident's hygiene and feeding concerns. SS will continue to follow up as needed. During an observation on 9/22/2025 at 1:40 PM with R128, it was observed R128 had a dark brown substance under his fingernails. During an observation on 9/25/2025 at 11:55 AM with R128, it was observed R128's fingernails had a dark brown substance under them. During an interview on 9/22/2025 at 1:40 PM with R128, stated he received bed baths on a regular basis. During an interview on 9/24/2025 at 8:20 AM with Complainant/Responsible Party (RP) 128 stated the staff did not bathe R128. RP128 said she had witnessed a dirt build up around R128's neck and his fingernails being dirty. During an interview on 9/25/2025 at 9:25 AM with Nurse Manager (NM) 3, stated she expected that a resident's fingernails would be cleaned thoroughly during their shower/bath (scheduled for two times a week) and as needed in between. During an interview on 9/25/2025 at 12:19 PM with Licensed Practical Nurse (LPN) 5 upon visualizing R128's fingernails LPN5 stated, They need to be cleaned.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records review, and facility policy review, the facility failed to ensure two residents (Resident (R) 131, R152) were free from significant medication errors out of a total of 33 sample residents during one of the two residents' insulin administration observation and record reviews. These failures had the potential to cause hyperglycemia or hypoglycemia episodes in insulin-dependent residents.Findings include:Review of the facility's policy titled, Medication Errors, dated September 2023, stated the facility must ensure it is free of medication error rate of five percent (%) or greater as well as significant medication error events.- Medication error, means the observed or identified preparation or administration of medications. which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication.- Significant medication error, means one which causes the resident discomfort or jeopardizes his/her health and safety.-The facility will consider factors indicating errors in medication administration, including. Medication administered not in accordance with the prescriber's order. Examples include, butnot limited to. Incorrect dose, route of administration, dosage form, time of administration. - If a medication error occurs, the following procedure will be initiated:a. The nurse assesses and examines the resident's condition and notifies the physician or healthcare practitioner as soon as possible.b. Monitor and document the resident's condition, including response to medical treatment ornursing interventions.c. Document actions taken in the medical record.d. Once the resident is stable, the nurse reports the incident to the appropriate supervisor andcompletes the incident or occurrence report.1. Review of R131's Face Sheet located in the electronic medical record (EMR) under the admission tab, indicated R131 was admitted to the facility with diagnoses including but not limited to type one diabetes and long-term use of insulin.Review of R131's physician's order, located under the Orders tab of the EMR, revealed an order for insulin Lispro, injection subcutaneously per sliding scale: if 180 - 210 = 2; 211 - 250 = 4; 251 - 290 = 6; 291 - 599 = 8, subcutaneously before meals and at bedtime for type one diabetes mellitus, start date 7/4/2025, scheduled for 6:30 AM, 11:30 AM, 4:30 AM and 9:00 PM.During the third-floor medication administration observation on 9/22/2025 at 9:51 AM, licensed practical nurse (LPN) 6 was observed performing a blood glucose (BG) check on R131; R131's BG was 245. LPN 6 did not follow the physician's order; he injected R131's 11:30 AM insulin order into R131's left arm earlier than the order time at 9:55 AM, and he documented it into the EMR at 10:03 AM.On 9/22/2025 at 10:15 AM, when asked, LPN6 stated that he administered the Lispro sliding scale order a little bit earlier than the order. He said R131's insulin was ordered to be given at 11:30 AM, and usually the software system would only allow him to administer it one hour earlier at 10:30 AM. However, since the software showed green and allowed him to administer it, he did. On 9/22/2025 at 11:24 AM, when asked, LPN3 stated that the sliding scale insulin for 11:30 AM should be given as early as 1 hour prior to 11:30 AM at 10:30 AM; however, lunch usually arrives around 12:30 PM, and she typically administers it at 12:00 PM (noon).On 9/22/2025 at 4:00 PM, when asked, R131 stated there was no staff rechecking his BG after receiving the Lispro 2 units at 9:55AM, and he did not eat any snacks after the insulin. The lunch that day was not served until around 1:30 PM.Review of R131's Medication Administration Report (MAR) included Location of Administration Report, dated 9/22/2025, located under the Orders tab of the EMR, revealedmore documentations that staff did not follow physicians' order to administer insulins as follows:Physician's order for insulin Lispro, injection subcutaneously per sliding scale: if 180 - 210 = 2; 211 - 250 = 4; 251 - 290 = 6; 291 - 599 = 8, subcutaneously before meals and at bedtime for type one diabetes mellitus, start date 7/4/2025, scheduled for 6:30 AM, 11:30 AM, 4:30 AM and 9:00 PM. Thirty of 67 administrations were given late, some examples included as follows:- 9/7/2025 due at 9:00 PM not administrated until 9/8/2025 at 2:28 PM.- 9/10/2025 due at 9:00 PM not administrated until 9/11/2025 at 3:34 AM.- 9/11/2025 due at 9:00 PM not administrated until 9/12/2025 at 6:01 AM.- 9/18/2025 due at 11:30 AM not administrated until 4:42 at PM.- 9/18/2025 due at 9:00 PM not administrated until 9/19/2025 at 1:45 AM.- 9/19/2025 due at 9:00 PM not administrated until 9/20/2025 at 1:16 AM.Physician's order for insulin Lispro, injection subcutaneously 8 units two times a day for type one diabetes mellitus, start 7/10/2025, scheduled at 12:00 PM and 5:00 PM. Ten of 39 administrations were given late, some examples included as follows:- 9/9/2025 due at 12:00 PM not administrated until 2:04 PM.- 9/11/2025 due at 5:00 PM not administrated until 6:26 PM.- 9/15/2025 due at 5:00 PM not administrated until 6:33 PM.- 9/18/2025 due at 12:00 PM not administrated until 4:42 PM.- 9/21/2025 due at 12:00 PM not administrated until 1:40 PM.-