

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  115129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/11/2025
NAME OF PROVIDER OR SUPPLIER  Nurse Care of Buckhead		STREET ADDRESS, CITY, STATE, ZIP CODE  2920 Pharr Court South NW Atlanta, GA 30305	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, resident and staff interviews, and record review, the facility failed to ensure incontinence pads were available for one resident (Resident (R) 21), reviewed for incontinence supplies from a sample of 45. This failure had the potential to increase skin breakdown for R21. Findings include: Review of R21's Resident Face Sheet, located in the resident's electronic medical record (EMR) under the profile tab, revealed the resident was admitted to the facility on [DATE] with a diagnosis of acute kidney failure, morbid obesity, and retention of urine. Review of R21's annual Minimum Data Set (MDS), located in the resident's EMR under the MDS tab with an Assessment Reference Date (ARD) of 11/07/2025, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R21 was cognitively intact. The MDS revealed R21 required substantial/maximal assistance with toileting and was always incontinent. Review of R21's Care Plan, revised 10/21/24 and located in the EMR under the Care Plan tab, revealed, [Resident name] has the potential for pressure ulcer/injury development related to morbid obesity, incontinency and the need for assist [sic] with toileting, hygiene, bed mobility and transfers. During an interview on 12/08/2025 at 12:12 PM, R21 said he wore a size 5X brief and required one at all times. He said several weeks ago, during the weekend, he was told by staff that they were out of his size of briefs and did not have any incontinent pads. R21 said they used a draw sheet instead of an incontinence pad, which caused discomfort when he had a bowel movement, as he typically does not get out of bed. He said he rarely gets out of bed. During an interview on 12/11/2025 at 12:54 PM, R21 said that after he was transferred into bed after his shower, he did not have an incontinence pad under him; currently, he has only a draw sheet. He stated it feels bad because I know I have to sit in urine for a while. During an observation and interview on 12/11/2025 at 9:00 AM, in the second-floor central supply closet with the Unit Manager Registered Nurse (UMRN), he confirmed there were no incontinence pads in the closet. During an observation and interview on 12/11/2025 at 9:15 AM, in the third-floor central supply closet with Unit Manager Licensed Practical Nurse (UMLPN) 2, she confirmed there were no incontinence pads in the closet. During an interview and observation on 12/11/2025 at 9:25 AM, the central supply closet was observed, and no incontinence pads were available. The Central Supply Manager (CSM) confirmed he was currently out of incontinence pads. The CSM said he places orders on Mondays, and the orders are received on Fridays. He said he orders according to the census, and that is how his budget is determined. He said he must be compliant with the budget and said quite often it is very difficult to have enough incontinence supplies because of the limited budget. During an interview on 12/11/2025 at 5:39 PM, the Director of Nursing (DON) and the Administrator stated that incontinence supplies should always be available for all residents.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 115129
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interview, record review, and review of the facility's policy titled Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property, the facility failed to report allegations of abuse within two hours and/or submit timely investigations for four of ten (R1, R2, R24, R25, R36 and R35) reviewed for abuse out of a total of 43 sample residents. This deficient practice had the potential to place residents at increased risk of abuse. Findings include:Review of the facility's policy titled Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property, dated 07/2025, revealed, . Each resident has the right to be free from verbal, sexual, physical and mental abuse . [Investigation] findings should be reported to the appropriate governing agencies . 1. a. Review of R1's admission Record, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia. Review of R11's quarterly Minimum Data Set (MDS), located in the resident's EMR under the MDS tab and with an Assessment Reference Date (ARD) of 11/13/2025, revealed R11 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R1 was cognitively intact.b. Review of R2's admission Record, located in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit.Review of R2's quarterly MDS, located in the resident's EMR under the MDS tab and with an ARD of 11/13/2025, revealed R2 had a BIMS score of six out of 15, indicating R2 was moderately cognitively impaired.Review of Facility Incident Report Form, dated 08/23/2025, revealed, A resident reported concerns regarding interactions between [R1] and [R2] as the two have been observed kissing.The Facility Incident Report Form revealed the initial incident between R1 and R2 occurred on 08/23/2025 and was reported timely to the governing agency.Review of the External Email Re: Report 202025-09121 revealed the final investigation of the incident between R1 and R2 that occurred on 08/23/2025 was submitted to the governing agency on 09/15/2025.2. a. Review of R24's admission Record, located in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, severe with psychotic disturbance.Review of R24's Care Plan, located in the resident's EMR under the Care Plan tab and revised on 09/18/2025, revealed R24 was cognitively impaired.b. Review of R25's admission Record, located in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses that included vascular dementia.Review of R25's Care Plan, located in the resident's EMR under the Care Plan tab and revised 11/07/2025, revealed R25 was cognitively impaired.Review of a Facility Incident Report Form, dated 11/27/2025, revealed, [R24] was observed walking behind [R25], who was seated in a chair. During this interaction, [R24] made contact with [R25] using a plastic utensil, resulting in a skin tear to [R24]'s hand and finger. The Facility Incident Report Form revealed the initial incident between R24 and R25 occurred on 11/27/2025 and was reported timely to the governing agency. Review of the External Email Re: Report 202025-13275 revealed the final investigation of the incident between R24 and R2025 that occurred on 11/27/2025 was submitted to the state agency on 12/09/2025.During an interview on 12/11/2025 at 5:39 PM, the Administrator stated she knew her investigations were late. She stated she submits them for review to her leadership, but did not follow up in a timely manner. The Administrator stated she was working on being more timely.3. a. Review of R36's admission Record, found in the EMR under the Profile tab, revealed that the resident was admitted to the facility on [DATE] with diagnoses including dementia and cognitive communication deficit.Review of R36's five-day MDS, located in the resident's EMR under the MDS tab and with an ARD of 07/20/2025, revealed R36 had a BIMS score of six out of</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>15, indicating severe cognitive impairment. b. Review of R35's admission Record, found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including other sequelae of cerebral infarction and vertigo of central origin. Review of R35's quarterly MDS, located in the resident's EMR under the MDS tab and with an ARD of 10/29/2025, revealed R35 had a BIMS score of 15 out of 15, indicating R35 had no cognitive impairment. Review of Facility Incident Report Form, dated 10/16/2025, revealed an incident of Other-Inappropriate touching between residents. The Facility Incident Report Form revealed the initial incident between R36 and R35 occurred on 10/08/2025. The final investigation of the incident between R36 and R35 that occurred on 10/08/2025 was submitted to the state agency on 10/23/2025. During an interview on 12/11/2025 at 5:40 PM, the Administrator said that she wanted the initial incident report submitted in two hours, and the completed investigation should be turned in within five days. She stated that she was not sure why the initial report was late, but confirmed that sometimes things were late due to documentation being reviewed by additional parties prior to being submitted to the state agency.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews, record review, and review of the facility's policy titled Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property, the facility failed to conduct a thorough investigation for incidents of potential abuse for seven of ten residents (Resident (R) 1, R2, R24, R25, R35, R36, and R37) reviewed out of 43 sampled residents, for potential physical resident-to-resident abuse for R1 and R2, R24 and R25, and R35 and R36, and verbal resident-to-resident abuse for R35 and R37. The failure to investigate potential allegations of abuse for facility residents placed the residents at risk of abuse. Findings include:</p> <p>Review of the facility's policy titled Prevention of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property, dated 07/2025, revealed, . Each resident has the right to be free from verbal, sexual, physical and mental abuse . [Investigation] .All suspected cases of abuse or misappropriation of resident's property will be fully investigated by the Administrator, Abuse Coordinator, or designee. Interview person reporting the allegation. Interview all associates, residents and family members involved. Continue investigation to determine if other residents may be at risk for similar occurrences .</p> <p>1. Review of R1's admission Record, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia.</p> <p>Review of R11's quarterly Minimum Data Set (MDS), located in the resident's EMR under the MDS tab with an Assessment Reference Date (ARD) of 11/13/2025, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R1 was cognitively intact.</p> <p>Review of R2's admission Record located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included cognitive communication deficit.</p> <p>Review of R2's quarterly MDS, located in the resident's EMR under the MDS tab with an ARD of 11/13/2025, revealed a BIMS score of six out of 15, indicating R2 had moderate cognitive impairment.</p> <p>Review of the Facility Incident Report Form, dated 08/23/2025, revealed, A resident reported concerns regarding interactions between [R1] and [R2] as the two have been observed kissing. The Facility Incident Report Form revealed the initial incident between R1 and R2 occurred on 08/23/2025. The facility investigation revealed that the responsible party was notified, and staff education titled Staff Education: Resident Rights &amp; Consent in Relationship was provided to staff. The investigation did not include resident interviews.</p> <p>2. Review of R24's admission Record located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included dementia, severe with psychotic disturbance.</p> <p>Review of R24's care plan located in the resident's EMR under the Care Plan tab, revised on 09/18/2025, revealed R24 was cognitively impaired.</p> <p>Review of R2025's admission Record located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included vascular dementia.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R2025's care plan located in the resident's EMR under the Care Plan tab, revised 11/07/2025, revealed R2025 was cognitively impaired.</p> <p>Review of a Facility Incident Report Form, dated 11/27/2025, revealed, [R24] was observed walking behind [R25], who was seated in a chair. During this interaction, [R24] made contact with [R25] using a plastic utensil, resulting in a skin tear to [R24]'s hand and finger. The Facility Incident Report Form revealed the initial incident between R24 and R25 occurred on 11/27/2025 and was reported timely to the governing agency.</p> <p>During an interview on 12/11/2025 at 5:39 PM, the Administrator said she was not aware that she should interview residents when she was investigating abuse. She said she thought she should only interview residents if they witnessed the incident.</p> <p>3. a. Review of R36's admission Record, found in the EMR under the Profile tab, revealed that the resident was admitted to the facility on [DATE] with diagnoses including dementia and cognitive communication deficit.</p> <p>Review of R36's five-day MDS, located in the resident's EMR under the MDS tab and with an ARD of 07/20/2025, revealed R36 had a BIMS score of six out of 15, indicating severe cognitive impairment.</p> <p>b. Review of R35's admission Record, found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including other sequelae of cerebral infarction and vertigo of central origin.</p> <p>Review of R35's quarterly MDS, located in the resident's EMR under the MDS tab and with an ARD of 10/29/2025, revealed R35 had a BIMS score of 15 out of 15, indicating R35 had no cognitive impairment.</p> <p>Review of Facility Incident Report Form, dated 10/16/2025, revealed a potential incident of Other-Inappropriate touching between residents, on 10/08/2025, that staff allegedly reported R35 was seen with his hand between the legs of R36 on top of her brief. The facility immediately separated R35 and placed residents on different floors. Both residents were placed on increased observation. Trauma, skin, and pain assessments were completed for both residents. No injuries, redness, or discolorations were identified. The responsible party, the physician, and the police were notified of the allegation. Investigation revealed: R35 denied touching the resident sexually. Certified Med Tech (CMT) 2 was the only identified witness, and documented that she observed R35, .resident was touching between her legs (R36).asked why are you touching her, please remove yourself now. CMT2 documented that she got the patient safe, and then told the unit manager. Five additional staff were interviewed, but none witnessed the incident. The investigation determined that .both residents were clothed, and no behavior was observed that definitely indicated sexual intent.staff member intervened immediately, and both residents were calm and cooperative following the redirection.</p> <p>Record review revealed there was an incomplete investigation of the alleged resident-to-resident abuse incident between R35 and R36 on 10/08/2025. Witness statements were completed only for the potential assailant R35, five CNAs, and the one staff witness (CMT2) at the facility. Additional residents from the facility were not interviewed to determine if they felt safe residing on the same unit with R35, or if they had experienced any resident-to-resident abuse from R35.</p> <p>During an interview on 12/11/2025 at 4:10 PM, CMT2 stated that she was the only person to see the</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>incident between R35 and R36. She said she observed R35 sitting near R36. She said R35 was observed placing his hand on her upper thigh. CMT2 said she went over and removed his hand before he could actually place it in her private area. CMT2 stated, he never had a chance to actually touch her groin or brief area. She said that she had additional staff help to separate them and keep R36 safe, and then she reported it.</p> <p>During an interview on 12/11/2025 at 5:40 PM, the Administrator said that for abuse investigations, she would interview staff and residents if they had been present for the alleged abuse incident. She stated that she was not aware that she should interview other residents, but confirmed she should be more diligent about getting more resident interviews and witness statements.</p> <p>4. a. Review of R37's admission Record located in the EMR under the Profile tab revealed an admission date of 10/24/24 with a medical diagnosis that included bipolar and dementia.</p> <p>Review of R37's annual MDS assessment located in the MDS tab in the EMR, with an ARD of 10/06/2025, revealed a BIMS assessment with a recorded score of 15 out of 15, which indicated no cognitive impairment.</p> <p>b. Review of R35's admission Record, found in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including other sequelae of cerebral infarction and vertigo of central origin.</p> <p>Review of R35's quarterly MDS, located in the resident's EMR under the MDS tab and with an ARD of 10/29/2025, revealed R35 had a BIMS score of 15 out of 15, indicating R35 had no cognitive impairment.</p> <p>Review of Facility Incident Report Form, dated 09/18/2025, revealed a potential incident of Other-Inappropriate comments, on 09/18/2025, that R37 alleged R35 was making sexually inappropriate comments and comes in her room without permission. The facility immediately separated R35 and placed him on one-to-one supervision during the investigation. The responsible party, physician, and police were notified of the allegation. The investigation revealed: R35 confirmed he had made comments to R37, intended no harm, sat with her at meals, and was not aware that it was a concern to R37. R35 agreed to move to a different floor. R37 was interviewed and stated that R35 had told her he wanted to get into bed with her to keep her warm. R37 also stated there had been no physical contact with R35. The investigation revealed during a trauma assessment for R37, that she had a history of domestic violence, child abuse, and sexual harassment. The facility substantiated the allegation between R35 and R37 for inappropriate resident-to-resident verbal conduct and boundary violation.</p> <p>Record review revealed there was an incomplete investigation of the alleged resident-to-resident abuse incident between R35 and R37 on 09/18/2025. Witness statements were completed only for the potential assailant R35, the resident victim R37, one CNA, and the maintenance director at the facility. Neither the CNA nor the maintenance director observed a concern with R35 and R37 interactions. No additional staff were interviewed to determine if they had observed any other potential resident-to-resident abuse concerns with R35. Additional residents from the facility were not interviewed to determine if they felt safe residing on the same unit with R35, or if they had experienced any resident-to-resident abuse from R35.</p> <p>During an interview on 12/11/2025 at 5:40 PM, the Administrator said that for abuse investigations, she would interview staff and residents if they had been present for the alleged abuse incident.</p> <p>(continued on next page)</p>		

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F 0610  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	She stated that she was not aware that she should interview other residents, but confirmed she should be more diligent about getting more resident interviews and witness statements.		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews, record review, and review of the facility's policies titled Applied Body Mechanics - Resident Handling Techniques and Wandering and Missing Residents, the facility failed to ensure one of 45 sampled residents (R) (R21) was safely transferred. In addition, the facility failed to ensure adequate supervision and monitoring for three of 45 sampled Rs (R4, R5, and R3) related to elopement. These deficient practices had the potential to place R21, R4, R5, and R3 at risk of avoidable accidents, injuries, and a diminished quality of life. Findings include:</p> <p>Review of the facility's policy titled, Applied Body Mechanics &amp; Resident Handling Techniques, dated 06/2025, revealed, . Use mechanical lift devices (e.g., full-body lift) when transferring or repositioning residents who are heavy, cannot bear weight, and are not able to cooperate. The mechanical device, not the caregivers, does the living Portable lift devise (sling type) are used to lift residents who are totally dependent, are partial or non-weight bearing, are very heavy, or have other physical limitations. Mechanical lifts are generally used for .chair or floor to bed, for bathing and toileting.</p> <p>A review of the facility's policy titled Wandering and Missing Residents, dated 05/2025, revealed that it is the policy of the Center to ensure the safety and well-being of each resident within the environment of the center while meeting their needs and sustaining a quality of life they can enjoy. Residents are not considered wandering or missing if the resident is on center premises/being chaperoned by the Center staff or a family member. Through security management system residents will have freedom to ambulate safely while maintaining a functioning egress to the doors. 1. Review of R21's undated Resident Face Sheet, located in the resident's electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with a diagnosis of muscle weakness and morbid obesity.</p> <p>Review of R21's annual Minimum Data Set (MDS), located in the resident's EMR under the MDS tab with an Assessment Reference Date (ARD) of 11/07/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R21 was cognitively intact. The MDS revealed R21 did not use a wheelchair, required substantial/maximal assistance with lying to sitting on side of bed, sit to stand was not attempted due to medical conditions or safety concerns, and chair/bed to chair transfer was not attempted due to medical conditions or safety concerns.</p> <p>Review of R21's Care Plan, revised 10/21/24 and located in the EMR under the Care Plan tab, revealed, .[Resident name] has a deficit in activities of daily living (ADL) self-care performance deficit r/t (related to muscle weakness. There was no outcome identified. Interventions included .chair /bed to chair transfer-substantiate/max assistance. created 04/19/25.</p> <p>Review of R21 weights under the Weights and Vitals tab, R21 weighed 323 lbs (pounds) on 11/13/25. The weights were obtained using a mechanical lift.</p> <p>During an interview on 12/11/25 at 12:54 PM, R21 said he had just returned from his shower. He said, My shower was good, only they dropped me when they tried to get me into bed. He said there were five staff members in the room. He said he had not stood up in a while, so it was difficult. He said he was not injured during the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/11/25 at 1:05 PM, Certified Nurse Aide (CNA) 5 said that, after R21's shower, she and the (Unit Manager Licensed Practical Nurse) UMLPN 2 were in the process of transferring R21 to bed when his feet started to bend towards the back of his chair. She said, then she and UMLPN2 lowered him to the floor. She said the Maintenance Director (MD) and the Maintenance Tech (MT) entered the room after the UMLPN 2 called out to the MT as he was walking by R22's room. CNA 5 said after the MD and the MT came in, both the Assistant Directors of Nursing (ADON) and ADON2. She said they all lifted R21 from the floor to his bed. CNA 5 stated that, normally, they would use a mechanical lift on a resident of that size, and said she did not know why they did not use the lift that day.</p> <p>During an interview on 12/11/25 at 1:05 PM, UMLPN 2 said they needed the MD, the MT, and two CNAs to lift R21. She said normally a resident the size of R21 would require a mechanical lift, but they did not use one; she did not know why. UMLPN 2 said they did not use a gait belt to assist with his transfer</p> <p>During an interview on 12/11/25 at 1:23 PM, the Physical Therapist (PT) said prior to R21's shower, we (PT and Occupational Therapist (OT)) were completing an evaluation to determine his balance when sitting on his bed, upper body dressing and upper body range of motion (ROM) while using a gait belt (sturdy fabric strap placed around a person's waist to help caregivers safely assist them with walking, standing, or transferring between surfaces). The PT said R21 had multiple barriers, including balance, morbid obesity, neuropathy, and a diabetic leg wound. He said he doubted R21 would ever stand again. The OT said that after they completed the evaluation, they asked the UMLPN 2 how they were going to transfer R21 after the shower. The OT said UMLPN 2 said they would use a mechanical lift. Both the PT and OT agreed that if a resident required more than two people to assist with a transfer, a mechanical lift should be used. The OT said R21 required more than two people for a transfer. The OT said if staff were concerned about the transfer, they could have asked therapy for assistance.</p> <p>During an interview on 12/11/25 at 1:48 PM, the MT said that while walking by R21's room, he noticed the PT, OT, UMLPN 2, and CNA5 assisting R21. R21 had a gait belt on, and the four staff members picked R21 up and placed him in the shower chair. After the shower, MT stated he was called by the UMLPN 2 over the walkie-talkie to come into R21's room. When he arrived, R21 was lying on the floor, and there were two CNAs in the room and UMLPN2. The MD entered the room and ADON and ADON 2 next. MT said he did not see a gait belt on the resident or a mechanical lift in the room. He said there were three staff at R21's head, one staff on each side of R21, and two staff at R21's feet. The MT said they lifted R21 into his bed from the floor.</p> <p>During an interview on 12/11/25 at 2:06 PM, ADON2 said that when he walked in the room, R21 was lying on the floor, flat on his back. He said a resident R21's size, they would typically use a mechanical lift.</p> <p>During an interview on 12/11/25 at 5:29 PM, the Restorative CNA (RCNA) said that a resident would need a mechanical lift based on their weight and disabilities. She stated R21 always required a mechanical lift.</p> <p>During an interview on 12/11/25 at 5:39 PM, the Director of Nursing (DON) and the Administrator agreed that staff should follow R21's transfer status and use a mechanical lift.</p> <p>2. Review of R4's Resident Face Sheet found in the EMR under the Profile tab revealed R4 was admitted to the facility on [DATE], with diagnoses that included schizophrenia, history of falling, vascular dementia, and major depressive disorder.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MDS found under the MDS tab of the EMR with an ARD of 09/19/25, revealed R4 was assessed to have scored a zero out of 15 on the BIMS, which indicates severe cognitive impairment. The resident was also coded as needing supervision while ambulating.</p> <p>A review of R4's elopement evaluation scores (Moderate Risk 5-8, High Risk 9-11) revealed that R4 was determined to be at moderate risk for elopement. The scores included on 06/08/25, he scored a two, on 07/05/25, he scored a seven, on 07/12/25, and on 08/07/25, he scored a four, and on 11/08/25, he scored an eight.</p> <p>A review of the Comprehensive timeline &amp;dash; Elopement incident for R4's elopement indicated that on 07/05/25 at 9:00 AM, the receptionist observed R4 coming down from the 5th floor unit to the 1st floor, unaccompanied. The receptionist made multiple calls to the 5th-floor unit, but contact was unsuccessful. At 10:30 AM, the receptionist realized that R4 was no longer in the front lobby or seated near the kitchen door. The receptionist contacted the 5th-floor unit to confirm if R4 had returned to his floor, and the 5th-floor staff verified that R4 was not accounted for, and an emergency alert was initiated. At 10:38 AM, a code orange (code for elopement). The intercom system was inoperable, and staff went to every floor to advise other staff of code orange, and a review of the video surveillance was initiated. At 10:40 AM, R4 was located across the street from the facility by a staff member. R4 ambulated across the street and was found alone sitting in the triangle where facility staff usually smoke. There were no staff in the area at the time, and residents did not smoke. Further review of the incident revealed that R4 was alert and oriented to person and place only. R4 was noted to be confused, impulsive, an active exit seeker, and a wanderer.</p> <p>A review of the Root Cause Analysis: Elopement/Exit Seeking Events, dated 07/05/25, in the section titled Why did the above happen? revealed that the incident occurred due to a failure in communication, a lack of immediate staff response, and the absence of appropriate safety systems for residents identified as elopement risks. Although the receptionist recognized the resident near the exit door and tried to notify nursing staff, the call went unanswered, and no further steps were taken to ensure the resident's safe return to his unit. There was no escalation process in place to address unanswered calls or to prompt in-person intervention. Additionally, there were no physical safeguards or secure access to prevent the residents from exiting the facility unnoticed. As a result, the residents remained unsupervised in a public area and were able to leave the premises without staff awareness.</p> <p>Further review of the form in the section titled Process involvement revealed that the fifth floor, which houses multiple residents with cognitive impairment and exit-seeking tendencies, is not a secure unit. There was no formal process or standard protocol in place for lobby management of at-risk residents. Additionally, there was no system to alert staff when residents identified as elopement risks accessed or left the building. This highlights procedural weaknesses in both physical security and staff communication practices.</p> <p>A review of R4's Care plan, found under the Care Plan tab of the EMR updated on 07/05/25, revealed R4 was at risk for wandering/elopement, identified exit seeking, exploring his environment, and others' rooms, which included the intervention to place R4 on one-on-one monitoring until cleared by the medical provider. No further interventions were updated in the care plan after the date of 07/05/25.</p> <p>3. Review of R5's Resident Face Sheet located in the resident's EMR under the Profile tab revealed R5 was admitted to the facility on [DATE] with admitting diagnoses that included a history of</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>falling, type 2 diabetes, and cognitive communication deficit.</p> <p>Review of the MDS found under the MDS tab of the EMR with an ARD of 09/15/25, indicated R5 was assessed with a BIMS score of 11 out of 15, indicating that R5's cognition was moderately impaired. R5's mobility was determined to be independent with the use of a wheelchair.</p> <p>A review of the elopement risk scores under the assessments tab of R5's EMR revealed that R5 was moderately at risk for elopement. On 06/08/25, she scored a seven, on 07/05/25, and on 08/07/25, she scored a six, and on 11/21/25, she scored an eight.</p> <p>A review of the signed staff statement, provided by the facility, dated 06/08/25, by Receptionist (RCP) 1 stated that she was on the phone when she saw R5 quickly scoot out of the main doors. RCP1 put the phone down and asked Licensed Practical Nurse (LPN) 11 to go outside and bring R5 back inside.</p> <p>A review of the signed staff statement, provided by the facility, dated 06/08/25, by LPN11 stated she was coming out of the elevator when another resident told her that a resident had just gone outside. When the Administrator asked LPN11 if RCP1 spoke with her, LPN11 stated that RCP1 may have said something to her, but there was a lot going on in the lobby, and she just went looking for the resident who got out of the main door. She found R5 just past the end of the carport. LPN11 asked R5 to come back inside, but was reluctant. Then, RCP1 came outside to help me get R5 back inside the building.</p> <p>A review of the form titled Elopement Drill form found in the Facility Reported Incident packet, dated 06/08/25, revealed that some staff did not know what code orange was when asked, Did the staff respond immediately to their search assignments?</p> <p>A review of the form titled Elopement Drill form found in the facility reported incident packet, dated 06/08/25, also revealed that the facility intercom was not working in all areas, staff needed more training on code meaning and code response, and the elopement protocol needs further review.</p> <p>A review of R5's Progress Note located under the Progress Note tab of the EMR dated 06/08/25, by Registered Nurse (RN) 3 revealed, R5 was reported to have exited the front door from the main lobby and proceeded into the parking lot. R5 remained on facility grounds and did not leave the facility campus. Per RCP1, the nursing staff was alerted. Assigned nurse LPN11 escorted R5 back into the facility without protest or complications and safely returned to the designated unit, and was joyfully received by the floor staff.</p> <p>A review of R5's Care Plan, located under the Care Plan tab of the EMR, dated 06/09/25, revealed that R5 was at Risk for wandering / Elopement, evidenced by wandering and exploring her environment and seeking new environments. The care plan included updated interventions that included identifying if there are triggers for wandering / eloping, identifying if there is a pattern and purpose of wandering, and Social Services to facilitate a family conference for support, distracting the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books.</p> <p>4. Review of R3's Resident Face Sheet located under the resident's EMR under the Profile tab revealed the resident was initially admitted to the facility on [DATE] on the 4th floor with diagnoses that included nontraumatic intracranial and intracerebral hemorrhage, dysphagia, and cognitive</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>communication deficit.</p> <p>Review of R3's quarterly MDS located under the resident's EMR, under the Profile tab, with an ARD of on 08/05/25, indicated the resident had a BIMS score of 15 out of 15, indicating that R3's cognition is intact.</p> <p>A review of R3's Elopement Risk Assessment, dated 07/05/25, revealed that R3 scored a zero, indicating that R3 was not at risk for elopement.</p> <p>A review of the Facility Reported Incident 5-day investigation, dated 08/13/25, further revealed that staff discovered that R3 was last seen at 10:30 PM on 08/06/25 and that the assigned nurse, LPN10, responded by stating that R3 was just downstairs and took no further action. At 3:30 AM on 08/07/25, LPN10 noted that R3 was not in his room and failed to notify the house supervisor as required.</p> <p>A review of the signed staff statement, dated 08/07/25, by LPN10 revealed that upon printing the unit census and doing a head count for her shift, it was reported to her that R3 was not in his room. LPN10 further stated that upon receiving the medication cart keys the night before, she did rounds, but she did not enter all the rooms while administering medications to the residents assigned to her.</p> <p>A review of a Progress Note, located in the EMR under the Progress Note tab, dated 08/07/25, by LPN10, revealed that R3 was reported missing from the 2nd floor unit at 7:20 AM and has not been in his bed or the unit throughout the 11:00 PM to 7:00 AM shift.</p> <p>A review of a Progress Note, located in the EMR under the Progress Note tab, dated 08/07/25, by LPN11, revealed that he contacted the resident via his cellphone number, but there was no answer. LPN11 also contacted the family, and voicemail picked up the call without any callback throughout his shift.</p> <p>A review of a Progress Note, dated 08/09/25, by UMLPN1 revealed that R3 has not returned to the facility. UMLPN1 contacted the family, but it only continued to ring with no answer, and left a voicemail message to find out if they knew where R3 was.</p> <p>A review of a Progress Note, located in the EMR under the Progress Note tab, dated 08/10/25, by the Administrator revealed that she contacted the family and continued not to get any call backs. She contacted the local hospitals to see if R3 was admitted . She also contacted the R3's cellphone number, but no call back was received either.</p> <p>A review of a Progress Note, located in the EMR under the Progress Note tab, dated 08/13/25, by the Administrator revealed that R3 returned to the facility on [DATE] at 2:30 PM, was ambulating without assistance, accompanied by three friends. The Administrator inquired if they could do a physical assessment, and R3 said, No. R3 stated he would like to leave the facility, and the Administrator offered him to sign an AMA [against medical advice] form, but he refused to sign and left the facility campus.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on staff interviews, record review, and review of the facility policy titled Insulin Administration, the facility failed to administer insulin as ordered by the physician for one of three residents (Resident (R) 40) reviewed for medication administration out of a sample of 45. This failure had the potential to cause the resident to have uncontrolled blood sugar levels. Findings include: Review of the facility's policy titled Insulin Administration, dated 06/2025, revealed, Policy: Special precautions should be followed when administering insulin . The type of insulin, dosage requirements, strength, and method of administration should be verified to ensure that it corresponds with the order on the medication sheet and the physician's order. Any discrepancies should be reported to the Charge Nurse or designee. The resident's physician should be notified of any discrepancies or adverse drug reactions .Review of R40's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses including type two diabetes mellitus with hyperglycemia, hyperlipidemia, and acquired absence of the right and left leg below the knee. Review of R40's quarterly Minimum Data Set (MDS), located in the resident's EMR under the MDS tab and with an Assessment Reference Date (ARD) of 11/04/2025, revealed R40 had a Brief Interview for Mental Status (BIMS) score of twelve out of 15, indicating R40 was moderately cognitively impaired. It was recorded the resident received insulin on six of the last seven review days. Review of R40's Physician Orders tab of the EMR revealed an order, dated 12/18/2024, for Humulin 70/30 Subcutaneous Suspension (70-30), an insulin, 100 Units/ML (milliliter), inject 48 units subcutaneously in the morning at 6:00 AM. There were no physician parameters for this medication. Review of R40's Medication Administration Record (MAR) tab of the EMR revealed: August 202025 - the medication was not administered on 08/11/2025 and 08/22/2025 at 6:00 AM. The failure to administer scheduled Humulin was not documented or justified in the EMR. September 202025 - the medication was not administered on 09/03/2025, 09/06/2025, 09/07/2025, 09/14/2025, 09/17/2025, 09/22/2025, and 09/29/2025 at 6:00 AM. The Progress Notes, located in the EMR under the Progress Notes tab for 09/20/2025, revealed that Humulin was held due to blood sugar levels that were not associated with the scheduled Humulin, but rather the sliding scale insulin. October 2025 - the medication was not administered on 10/05/2025, 10/20/2025, and 10/30/2025 at 6:00 AM. The failure to administer scheduled Humulin was not documented or justified in the EMR on 10/05/2025 and 10/20/2025. The Humulin was documented as not administered on 10/30/2025 due to on route from pharm (pharmacy). November 2025 - the medication was not administered on 11/01/2025, 11/15/2025, 11/24/2025, 11/26/2025, 11/27/2025, and 11/29/2025 at 6:00 AM. The Progress Notes located in the EMR, revealed that Humulin was held on 11/01/2025 because resident has not eaten yet. The failure to administer scheduled Humulin was not documented or justified in the EMR on 11/15/2025, 11/24/2025, 11/27/2025, or 11/29/2025. On 11/26/2025, it was documented on route. Review of R40's Physician Orders tab of the EMR revealed an order, dated 12/18/2024, for Humulin 70/30 Subcutaneous Suspension (70-30) 100 Unit/ML (milliliter), inject 30 units subcutaneously in the evening at 5:00 PM. There were no physician parameters for this medication. Review of R40's MAR tab of the EMR revealed: August 2025 - the medication was not administered on 08/15/2025, 08/18/2025, 08/20/2025, and 08/29/2025 at 5:00 PM. The failure to administer scheduled Humulin was not documented or justified in the EMR on 08/15/2025 or 08/18/2025. The Progress Notes located in the EMR revealed that Humulin was held due to blood sugar levels that were not associated with the scheduled Humulin, but the sliding scale insulin on 08/20/2025, and was not administered on 08/29/2025 due to Pending pharmacy delivery. September 2025 - the medication was not administered on 09/27/2025 at 5:00 PM. The failure to administer scheduled Humulin was</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>not documented or justified in the EMR. October 2025 - the medication was not administered on 10/10/2025, 10/2025/2025, and 10/28/2025 at 5:00 PM. The failure to administer scheduled Humulin was not documented or justified in the EMR. November 2025 - the medication was not administered on 11/28/2025 at 5:00 PM. The Progress Notes located in the EMR revealed that Humulin was held due to blood sugar levels that were not associated with the scheduled Humulin, but rather the sliding scale insulin. During an interview on 12/10/2025 at 9:00 AM, R40 stated that she did not know why the facility did not administer her diabetic medications as ordered. R40 said that when she did not eat well, the nurses would sometimes not give her the scheduled diabetic medications. She stated this was an ongoing concern for the maintenance of her blood sugar. During an interview on 12/11/2025 at 10:08 AM, the Nurse Practitioner stated that she expected insulin orders to be followed as written by the physician. She stated if a resident had a scheduled Humulin order, then it should be given as ordered. The Nurse Practitioner stated if the resident had a sliding scale insulin order, it was to accommodate what additional insulin R40 would need after the Humulin had been given. She stated a resident needing both scheduled Humulin and a sliding scale insulin was often caused by the resident not having well managed blood sugars. During a concurrent interview on 12/11/2025 at 12:18 PM, Registered Nurse (RN) 4 and Unit Manager Licensed Practical Nurse (UMLPN) 1 confirmed that R40 received scheduled Humulin as well as sliding scale insulin. RN4 stated that R40 would receive Humulin regardless, and the sliding scale insulin would be administered according to the blood sugar levels. RN4 stated that a nurse would have to place a documented note in the EMR about why a resident had not received their scheduled medications. She stated the nurse could document a refusal, but otherwise, the Humulin insulin should be administered. UMLPN1 stated that scheduled Humulin should be given and would not be held for normal blood sugars. Upon review of R40's MAR, she stated she was not sure why a nurse would have held the Humulin, especially with blood sugars that were fine. During a follow-up interview on 12/11/2025 at 1:58 PM, UMLPN1 stated that she had reviewed the MAR for R40 and could see that Humulin had been held inappropriately. She stated that it was not okay to hold NPH Insulin (Neutral Protamine [NAME]) because it functioned differently from the sliding scale insulin. She stated nurses needed to give the Humulin insulin as ordered. During an interview on 12/11/2025 at 5:13 PM, the Director of Nursing (DON) stated that if a resident had a standing order for a medication, the nurse should give it as ordered. She stated that nurses should talk to the provider if they were worried about blood sugars being too low, such as below 70. The DON stated that if the resident's blood sugars were approximately 105-130, she would expect Humulin orders to be followed.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on observations, staff interviews, and facility document review, the facility failed to ensure that the Facility Assessment included an accurate and comprehensive review of the facility's resident population, including the identified secure memory unit located on the fifth floor. The failure to identify a secure unit for dementia care or behavioral health meant the facility assessment plan had potentially missed critical care needs, updating the assessment to reflect residents needing secured care, and revising emergency/care plans to include secure protocols and dedicated spaces. This deficient practice had the potential to affect the care provided to the facility population and the training required for both direct and indirect care staff. Findings include: Review of the Facility Assessment, dated 4/28/2025, revealed it did not include any indication or recognition of an identified secured memory unit located on the fifth floor of the facility. Facility-provided documentation revealed four individual resident units on four floors of the building, with the resident population evenly distributed across the four residential floors. Facility-provided documentation revealed that 53 residents resided on the fifth floor of the facility, accounting for approximately 25% of the facility's current population. This population was not identified in the current Facility Assessment to ensure appropriate assessments and monitoring were in place for the safety of all facility residents. Observations on four of four survey days revealed that access to the fifth floor was limited by the keypad and code provided to staff. This code was required to access the fifth-floor elevators when leaving the unit. During staff interviews, this was identified as the secured unit, and the residents were not provided with this access code. During an interview on 12/8/2025 at 11:15 am, Certified Med Tech (CMT) 4 stated that the fifth floor was a secure unit, and a code was necessary in order to use the elevator. During an interview on 12/10/2025 at 11:46 am, Certified Nursing Assistant (CNA) 10 stated that residents on the fifth floor were assisted to get up and down the elevator because they were not told the elevator code. CNA10 said that the fifth floor had been the Dementia and Behavioral unit since she had worked at the facility for three years. She stated that the staff would need to help someone get into the elevator because they were not permitted to give out the codes to anyone. During an interview on 12/10/2025 at 11:51 am, Registered Nurse (RN) 5 stated that the fifth floor was the Dementia Behavioral unit. RN5 stated that none of the residents knew the code to get on the elevator. During an interview on 12/10/2025 at 11:56 am, Charge Nurse Licensed Practical Nurse (CNLPN) stated that, since she had worked at the facility, the fifth floor had been the memory care and behavior unit. She stated that none of the residents knew the code to get on the elevator. CNLPN stated that the residents on the fifth floor were elopement risk residents. During an interview on 12/10/2025 at 12:10 pm, the Administrator stated that the fifth floor was not considered a secure unit but rather a mechanism for keeping residents at risk of elopement and wandering safe. She stated that the facility had installed an elevator keypad on the fifth floor in August or September of 2025. She stated that there were residents on the fifth floor who were at risk of elopement. She confirmed residents on this floor did not know the elevator keypad code to exit the unit. During an interview on 12/11/2025 at 5:18 pm, the Director of Nursing stated that the fifth-floor residents were identified as the dementia population. She stated that the facility worried about wandering for those residents. She stated the keypad for this unit was already in place when she started working at the facility in September 2025. During a follow-up interview on 12/11/2025 at 5:40 pm, the Administrator stated that although the facility had not called the fifth floor the secured unit, any person who could not leave the unit when they wanted to would be considered secured. She stated the facility</p> <p>(continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>went secured after Resident (R) 4 had eloped. She confirmed that the facility tended to have more wanderers with a risk of elopement, and that they would need to review the accuracy of the Facility Assessment, specifically for the 25% of the population residing on the fifth floor.</p>		