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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to properly label and date several items in the refrigerator. This failure had the possibility to expose 116 of 128 residents residing at the facility to food items that may have been spoiled. Findings include: During the Flash Tour of the kitchen on 9/22/2025 at 8:12 AM, there were items in the reach in fridge that were not labeled or dated. The items found were: two plates of salad, 12 small containers/bowls of dessert, and 16 small glasses of iced tea. The Dietary Manager (DM) was present and confirmed the findings. During an interview on 9/25/2025 at 8:45 AM, the DM stated the kitchen staff had been educated on labeling and dating all opened or stored items in the refrigerator. The DM explained whoever placed the items in fridge was responsible for labeling and dating those items.

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on staff interviews, record review, and facility policy review, the facility failed to monitor and follow up on weight loss for three of six sampled residents (Resident (R) 9, R10, and R23) reviewed for weight loss. This deficient practice had the potential to allow residents to continue to lose weight and not be monitored for supplements or change in diet.Findings include:Review of the facility's policy titled, Weight Monitoring revised January 2024 revealed, Policy: Based on resident's comprehensive assessment, the facility will ensure that all residents and maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that is not possible of resident preferences indicate otherwise. Compliance Guidelines: Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. 1. The facility will utilize a systemic approach to optimize a resident's nutritional status' This process includes:a. Identifying and assessing each resident's nutritional status and risk factors.b. Evaluating/analyzing the assessment information.c. Developing and consistently implementing pertinent approaches.d. Monitoring the effectiv.r.it of interventions and revising them as necessary. 5. A weight monitoring schedule will be developed upon admission for all residents a. Weights should be recorded at the time obtained. Mathematical rounding should be utilized.(i.e., if weight is X.5 pounds [lbs.] or more, round weight upward to the nearest whole pound.If weight is X.1 to X.4 [lbs.] round down to the nearest whole pound) . c. Residents with weight loss - monitor weight weekly.Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight. A significant change in weight is defined as:a. 5% (percent) change in weight in 1 month (30 days)b. 7.5% change in weight in 3 months (90 days)c. 10% change in weight in 6 months (180 days).1. Review of the electronic medical record (EMR) for R9 located in the Profile tab revealed R9 had been admitted to the facility with diagnoses of but not limited to peripheral vascular disease, paranoid schizophrenia, and vitamin D deficiency.Review of the quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 9/3/2025 revealed R9 had a Brief Interview for Mental Status (BIMS) score of four out of 15, indicating severe cognitive impairment.Review of R9's weights (wts) located in the EMR under the Wts/Vitals tab indicated on 6/2/2025 R9 weighed 203 lbs. and on 7/8/25 weighed 157 lbs. revealing a 22.6 % weight loss. A reweigh was conducted on 7/10/2025, indicating a 19.7 % loss, indicating a significant weight loss in one month.Review of R9's EMR located under the Progress Notes tab revealed a Nutrition/ Dietary Note, dated 7/9/2025, indicated R9 was discussed in patient review indicating a reweigh should be completed and the Registered Dietician (RD) would monitor and follow up as needed.Further review of R9's Dietary Progress Notes, indicated on 7/16/2025 recommended labs will be obtained and add patient to the weekly weights sheet.Further review of the weights for R9 revealed weekly weights were not obtained.During an interview on 9/24/2025 at 3:55 PM, the RD was asked about the weight loss. The RD stated, The resident wanted to lose weight. The RD was asked if it was appropriate to lose that much weight in a month. The RD stated that's why labs were requested. The RD was asked about the weekly weights. The RD stated the nursing staff were to conduct the weekly weights. The RD was asked how he followed up when there were no weekly weights as he recommended and as policy indicated. The RD stated the weekly weights were not done and should have been.During an interview on 9/25/2025 at 10:26 AM, Unit Manager (UM)2 was asked about weekly weights for R9. UM2 stated during the weight loss, UM2 was not the unit manager. UM2 stated, If there were any weights completed, they would have been placed in the EMR. If they are not there then it was not done.2. A review of the admission Record found in R23's EMR, under the Profile tab, indicated pertinent diagnoses included but were not limited to dysphagia, unspecified protein-calorie malnutrition, obesity, and Alzheimer's.Review of the annual MDS, with an ARD of 7/19/2025, found in R23's EMR, under the MDS tab, indicated R23 had a (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BIMS score of nine out of 15, which indicated the resident had moderate cognitive impairment. Further review revealed that R23 had a weight loss of 5% or more in the last month or a loss of 10% or more in the last six months and was not on a physician-prescribed weight-loss regimen.Review of R23's care plan, last revised on 9/22/2025, indicated R23 had unplanned/unexpected weight loss related to acute illness, dysphagia, advanced age, history of infection, and Alzheimer's disease. The pertinent intervention directed staff to monitor and evaluate any weight loss, determine the percentage lost, and follow facility protocol for weight loss.Review of R23's weights, dated 3/10/2025 through 9/10/2025, found in R20's EMR, under the Weights/Vitals tab, revealed R23 sustained a significant weight loss of 9.0 lbs. (5.65%) in 30 days (8/13/2025: 159.2 lbs. and 9/10/2025: 150.2 lbs.). Further review failed to reveal that the staff obtained weekly weights on R23 after noting a significant weight loss in 30 days.Review of the Patient At Risk (PAR) note, dated 9/9/2025, found in R23's EMR revealed staff discussed R23 during the weekly PAR Meeting; however, the note did not include any information related to the resident's significant weight loss, direction to reweigh R23, or obtain weekly weights.Review of the RD progress note, dated 9/17/2025, found in R23's EMR under the Progress Notes tab, indicated R23 had a significant weight loss of 5.7% in one month, 10.4% in three months, and 13.8% in six months. RD questions weights. However, weight loss was possibly related to R23's surgical wound, advanced age, history of infection, depression, and anxiety. Further review revealed that the RD reviewed R23's weight loss with the Interdisciplinary Team (IDT) during the PAR meeting. The IDT reported R23 had good oral intake, eating 75-100% of most meals. Nursing to weigh per protocol.During an interview on 9/24/2025 at 8:40 AM, the RD stated that R23 triggered for a significant weight loss. On 7/9/2025, the resident lost 9.1 lbs. (5.4%) in 30 days, prompting an increase in Med Pass (nutritional supplement) from twice to three times daily, which resulted in a minimal weight gain of 0.6 lbs. (0.38%). On 9/10/2025, the resident experienced an additional 9.0 lbs. of weight loss in 30 days, leading the RD to order a daily house shake supplement, in addition to the Med Pass. The RD confirmed that staff should weigh residents who have experienced significant weight loss, defined as 5% in 30 days, 7.5% in 90 days, or 10% in 180 days, on a weekly basis.During an interview on09/24/2025 at 10:07 AM, UM1 stated that she provided the Certified Nurse Aides (CNAs) with a list of residents whom they needed to weigh. UM1 stated that she reviews the weights to identify any discrepancies from the previous measurement and tends to reweigh residents if they have experienced significant weight loss since the last measurement. UM1 stated that if it was a true weight loss, she would notify the RD and Physician and discuss the residents with the IDT during the weekly PAR Meeting. During the PAR Meeting, the RD would notify them [unit managers] if he wants staff to reweigh the resident or obtain weekly weights. UM1 reviewed R23's weights and noted that staff did not obtain weekly weights on R23 and that no orders were written for weekly weights.During an interview on 9/24/2025 at 11:00 AM, the Director of Nursing (DON) stated that on 9/10/2025, they reviewed R23's weight loss during the weekly PAR Meeting. The DON stated that R23 had a weight loss of 9.0 lbs. in 30 days. During the PAR Meeting, the RD requested a reweigh of R23 and, depending on the results, directed staff to conduct weekly weights.During a follow-up interview on 9/24/25 at 4:15 PM, the RD stated that he reviewed the weight loss report weekly and discussed residents with weight loss during the weekly PAR Meeting. The RD stated that re-weighs should occur within 24 hours and that he did not recall if staff notified him of the results. Upon inquiry, the RD stated that he believed that he followed up on R23's reweight but could not provide any supporting documentation. The RD stated that since R23 triggered a significant weight loss, he expected staff to obtain weekly weights.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interview, record review, and facility policy review, the facility failed to provide a dignified dining experience for one of five residents observed for nutrition (Resident (R) 15. This failure had the potential to negatively impact quality of life and self-esteem of R15.Findings include:Review of a facility's policy titled, Promoting/Maintaining Resident Dignity, dated March 2025 indicated .It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality.All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.1. Review of R15's electronic medical record (EMR) titled, admission Record, located under the Profile tab, indicated the resident was admitted to the facility on [DATE].Review of R15's EMR titled quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 06/20/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which revealed the resident had moderate cognitive impairment. The assessment indicated the resident required set up assistance with his meals. During an observation on 9/22/2025 at 12:52 PM, LPN1 was in the main dining room and stood next to R15. LPN1 assisted the resident while eating his lunch meal and failed to sit across from the resident. LPN1 repeatedly provided the resident with bits of food while standing until 12:57 PM and then left the area.During an interview on 9/23/2025 at 10:25 AM, LPN1 confirmed he was standing while assisting R15 with his lunch meal and stated he should have sat across from the resident to feed the resident. LPN1 stated he needed to review the facility's policy on dignity to see if this situation was a dignity issue or not.During an interview on 9/23/2025 at 9:40 AM, LPN1 confirmed he should of sat with R15 to assist him with his meal and since standing next to the resident was a dignity issue. LPN1 stated it was more appropriate to have eye contact with the resident.2. Review of R80's EMR titled, admission Record, located under the Profile tab indicated the resident was admitted to the facility on [DATE].Review of R80's EMR titled, quarterly MDS, located under the MDS tab with an ARD of 8/20/2025 indicated the resident had a BIMS score of 14 out of 15, which revealed the resident was cognitively intact.During a medication pass observation on 9/22/2025 at 4:30 PM, CNA3 was overheard behind R15 and R80's closed door. Licensed Practical Nurse/Unit Manager (UM) 3 was present. CNA3 was overheard with a loud voice behind the door. UM3 confirmed she overheard the loud voice of CNA3 while the residents' door was shut. UM3 opened the residents' door and CNA3 was on her cell phone. CNA3 then opened the residents' door and confirmed she had answered her cell phone since her child called. UM3 stated when staff use their personal cell phone in a resident room, this was considered a dignity issue. CNA3 stated she should not have been on the phone in a resident room since the residents were in the room.An interview was conducted on 9/24/2025 at 2:13 PM with R80 and he stated he remembered CNA3 on her cell phone while in his room and stated this was disrespectful. During an interview on 9/24/2025 at 2:15 PM, R15 stated he did not remember the incident with CNA3 and answered her cell phone in his room.During an interview on 9/24/2025 at 4:16 PM, the Director of Nursing (DON) stated LPN1 should have sat down next to R15 while assisting the resident during his meal since this was a dignity issue. In addition, the DON stated CNA3 should not have answered her cell phone in a clinical setting since this was a dignity issue.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and review of the facility's policy, the facility failed to ensure two (Residents (R5) and R1) of a survey sample of 33 residents were invited to participate in the quarterly care plan meeting. This failure has the potential to violate resident rights, including the care plan not reflecting their preferences.Findings include:Review of R5's EMR failed to contain evidence that the resident was invited to her quarterly care conferences.During an interview on 9/22/2025 at 9:31 AM, R5 stated she did not get invited to her quarterly care conferences.During an interview on 9/23/2025 at 3:24 PM, the Director of Social Services (DSS) stated she invited residents who had a high BIMS score to their quarterly care conferences. The DSS confirmed that R5's representative was invited but not the resident.During an interview on 9/24/2025 at 2:45 PM, the DSS stated there were no prior quarterly care conferences identified for R5 in the EMR and confirmed R5 was her own representative.During an interview on 9/24/2025 at 4:16 PM, the Director of Nursing (DON) stated the residents were to be invited to their care conferences to be able to participate in the development of it. Findings include:Review of a facility policy titled, Comprehensive Care Plans, dated March 2025, indicated .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive assessment and quarterly MDS.1.Review of R5's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE].Review of R5's EMR titled envelope located under the Misc (Miscellaneous) tab indicated the resident's representative was invited to the resident's care conference. Review of R5's EMR titled quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference (ARD) of 7/17/2025 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which revealed the resident was cognitively intact. 2. Review of R37's admission Record located under the Profile tab in the EMR indicated R37 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), epilepsy, and diabetes.Review of R37's EMR revealed an annual MDS located under the MDS tab with an ARD of 8/21/2025 revealed a BIMS score of 15 out of 15, indicating intact cognition.Review of R37's EMR revealed Progress Notes located under the Progress notes tab revealed no indication of invitation or participation in any care plan conference meetings.During an interview on 9/22/2025 at 9:04 AM, R37 was asked about the care plan meetings every three months. R37 stated, I don't know anything about meetings.During an interview on 9/25/2025 at 9:30 AM, the Administrator was asked about the invitations to the care plan meetings. The Administrator stated the invitations are in the medical records but have not been scanned into the EMR yet.During an interview on 9/25/2025 at 1:30 PM, the Social Service Assistant (SSA) was asked how invitations were given to the residents. The SSA stated residents were given letters inviting them to their meetings. The SSA was asked for invitations for the last year for R37. The SSA could not provide invitations for the 6/3/2025 and 8/1/2025 meetings.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 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. **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 (continued on next page)

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	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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.- 9/22/2025 due at 12:00 PM not administrated until 2:16 PM.Physician's order for insulin Lantus, injection subcutaneously 10 units at bedtime for type one diabetes mellitus, start 7/10/2025, scheduled at 9:00 PM. Seventeen of 20 administrations were given late, some examples included as follows:- 9/5/2025 due at 9:00 PM not administrated until 9/6/2025 at 12:35 AM.- 9/7/2025 due at 9:00 PM not administrated until 9/8/2025 at 2:28 AM.- 9/8/2025 due at 9:00 PM not administrated until 9/9/2025 at 6:01 AM.- 9/15/2025 due at 9:00 PM not administrated until 9/16/2025 at 2:24 AM.- 9/10/2025 due at 9:00 PM not administrated until 9/11/2025 at 3:36 AM.- 9/15/2025 due at 9:00 PM not administrated until 9/16/2025 at 2:24 AM- 9/18/2025 due at 9:00 PM not administrated until 9/19/2025 at 1:46 AMPhysician's order for insulin Lantus, injection subcutaneously 20 units subcutaneously one time a day in the morning for type one diabetes mellitus, start 7/11/2025, scheduled at 7:30 AM. Twelve of 22 administrations were given late, some examples included as follows:-9/6/2025 due at 7:30 AM not administrated until 9:47 AM.- 9/7/2025 due at 7:30 AM not administrated until 10:05 AM.- 9/13/2025 due at 7:30 AM not administrated until 9:59 AM.- 9/15/2025 due at 7:30 AM not administrated until 9:07AM- 9/17/2025 due at 7:30 AM not administrated until 10:38 AM.- 9/18/2025 due at 7:30 AM not administrated until 11:03 AM.Review of R131's record revealed no documentation from the staff notifying the provider that insulin was administered early or too late. There was no documentation that R131 was being monitored for hyperglycemia or hypoglycemia.During an interview on 9/24/2025 at 4:22 PM, the Regional Director of Clinical Services (RDCS) stated if the medication was administered one hour earlier than the scheduled time, it was considered too early, and if administered after one hour past the scheduled time, it was considered late, and both were considered medication errors. The nurse should notify the provider and document it in the progress note.During an interview on 9/24/2025 at 4:44 PM, upon policy request, the Director of Nursing (DON) stated that there was no specific policy for insulin administration; instead, it should follow the Medication Administration policy. The DON stated that if a nurse administered medication late or too early, including insulin, the staff should contact the provider for further instruction, monitor the resident and document. The DON further verified the late administration of insulin injections on the MAR reports for R131. The DON stated that if the medication was given one hour before or after the scheduled time, it was considered late.2. Review of R152's Face Sheet located in EMR under the admission tab, indicated R152 was admitted to the facility on [DATE] with multiple diagnoses including type two diabetes.Review of R152's MAR included Location of Administration Report, dated 9/22/2025, located under the Orders tab of the EMR, revealed staff did not follow physicians' order to administer insulins as follows:Physician's order for insulin Glargine, injection subcutaneously 10 units at bedtime for type two diabetes mellitus, start 3/7/2025, discontinued 3/17/2025. Scheduled for 9:00 PM. Seven of 9 administrations were given late, some examples included as follows:- 3/7/2025 due at 9:00 PM not administrated until 11:42 PM.- 3/8/2025 due at 9:00 PM not administrated until 3/9/2025 12:04 PM.- 3/9/2025 due at 9:00 PM not administrated until 10:02 PM.- 3/12/2025 due at 9:00 PM not administrated until 10:05PM.- 3/13/2025 due at 9:00 PM not administrated until 10:05 PM.- 3/15/2025 due at 9:00 PM not administrated until 3/16/2025 1:16 AM- 3/16/2025 due at 9:00 PM not administrated until 10:39 PMPhysician's order for insulin Lispro, injection subcutaneously 5 units before meals for three times a day for type two diabetes mellitus, start 3/7/2025, discontinued 3/17/2025. Scheduled for 6:30 AM, 12:00 PM and 5:00 PM. Three of 29 administrations were given (continued on next page)

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	115110	A. Building B. Wing	09/25/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	late, some examples included as follows:- 3/8/2025 due at 12:00 PM not administrated until 4:07 PM.- 3/8/2025 due at 5:00 PM not administrated until 6:36 PM.- 3/16/2025 due at 12:00 PM not administrated until 1:39 PM.Review of R152's record revealed no documentation from the staff notifying the provider that insulin was administered early or too late. There was no documentation that R152 was being monitored for hyperglycemia or hypoglycemia.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and facility policy review, the facility failed to ensure that food preferences were honored for one out one of 33 sampled residents (Resident (R) 49).Findings include:Review of an undated facility policy titled, Resident Nutrition Services indicated .Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.Review of R49's electronic medical record (EMR) titled, admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE].Review of R49's EMR titled quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 7/19/2025 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which revealed the resident was moderately cognitively impaired.During an interview on 9/22/2025 at 9:54 AM, R49 stated she had requested a salad for lunch and dinner and wanted this regularly.During an interview on 9/22/2025 at 12:44 PM, Certified Nurse Aide (CNA) 8 confirmed that R49's lunch tray did not have a salad. During this interview, the resident presented her lunch meal ticket, and it revealed that the resident requested a salad per meal. The resident verified there was no salad on her meal tray during this observation.During an observation on 9/23/2025 at 12:48 PM, Licensed Practical Nurse (LPN)7 confirmed R49 did not have a salad on her lunch tray. An interview was conducted with the resident immediately after this observation and she presented a copy of her meal ticket, dated 9/23/2025.During an interview on 9/25/2025 at 8:29 AM the Dietary Manager (DM) confirmed that R49 had requested salads with her meals and he forgot to add the salad to the resident's trays.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and review of facility policies and manufacturer guidelines, the facility failed to ensure the glucometer disinfection procedure and infection control practice for hand hygiene were followed during a medication administration observation for blood glucose (BG) check for one resident (Resident (R)131) and during a wound care observation for one R59 observed out of 33 sample residents. These failures placed residents and staff at risk of cross contamination and infection.Findings include:1. Review of the facility's policy titled, Glucometer Disinfection, dated 1/1/2022, stated Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. The procedure included the following: a. Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose, testing strips, disinfecting wipes.b. Wash hands.c. Explain the procedure to the resident.d. Provide privacy.e. Put on gloves.f. Obtain capillary blood glucose sampling according to facility policy.g. Remove and discard gloves, perform hand hygiene prior to exiting room.h. Reapply gloves if there is visible contamination of the device or if the resident is HIV [human immunodeficiency virus] or H hepatitis B or C positive.i. Retrieve (2) disinfectant wipes from container.j - Using first wipe, clean first to remove heavy soil blood and/or other contaminant left on the surface of the glucometer.k. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions- Allow the glucometer to air dry.l. Discard disinfectant wipes in waste receptacle. Perform hand hygiene.On 9/22/2025 at 9:49 AM, during the third-floor medication administration observation, Licensed Practical Nurse (LPN) 6, who was assigned to the Long Hall medication cart (MC) for the third floor, began to prepare a BG check for R131. LPN6 did not disinfect the glucometer. He put the glucometer, and all the BG check supplies, including a pair of gloves, alcohol wipes, test strips, and lancets (needles), in his left top scrub pocket and walked to R131's room. LPN6 placed the glucometer on R131's bedside table next to a breakfast tray without a barrier. LPN6 did not perform hand hygiene prior to putting on gloves; he did not perform any disinfecting procedures on the glucometer prior or after entering R131's room. LPN6 inserted the testing strip into the glucometer and then performed a BG check. R131's BG was 245.On 9/22/2025 at 9:55 AM, LPN6 removed the gloves and put on a new pair of gloves without performing hand hygiene. LPN6 primed the Lispro insulin and gave four units of Lispro to R131 to his left arm. LPN6 then removed his gloves, walked back to his MC and placed the glucometer on top of his MC. LPN6 documented medication administration in the computer on the MC. LPN6 did not disinfect the glucometer after use and put it back in the MC's top drawer to the right.On 9/22/2025 at 10:11 AM, when asked, LPN6 stated he was oriented upon hiring for BG checks. LPN6 stated he should have, but he did not perform hand hygiene before and after putting on and removing the gloves for the BG check and insulin administration. LPN6 said he should have but did not disinfect the glucometer prior to and after use with bleach wipes with a contact time of around thirty seconds to three minutes. LPN6 further stated he should have but he did not place a barrier between the BG check supplies and R131's bedside table.During a review of the glucometer manufacturer's cleaning instruction and the packaging copy of the bleach wipes the facility used with the DON. The DON stated that the staff should follow the manufacturer's instructions on page forty-seven, option one, which states that cleaning and disinfecting can be completed by using a commercially available EPA [environmental protection agency]- registered disinfectant detergent or germicide wipe.The DON confirmed the staff would follow the package instruction for Microdot Bleach Wipe, EPA registration #37549-1-88459, under the Directions for Use. Apply towelette and wipe desired surface.A 30 second contact time is required to kill bacteria and viruses .a 1 minute contact time is required to kill Candida albicans. and a 3 minute contact time is required to kill Clostridium difficile spores.On 9/22/2025 at 12:39 PM, the DON provided and confirmed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the list of two residents who had hepatitis C, and one resident had HIV, three of them all receiving BG check and insulin injections in the facility.On 9/23/2025 at 8:38AM, the Regional Director of Clinical Services (RDCS) stated that the HIV and hepatitis C residents have their individual glucometers located in the MC at the bottom drawer.2. According to Wound Care Essentials: Practice Principles (5th ed., [NAME] & Ayello, 2020), published by [NAME] & [NAME], hand hygiene is a critical component of infection prevention during wound care procedures. The text emphasizes that healthcare personnel must perform hand hygiene both before and after any wound care activity, including between glove changes and when transitioning between wound sites. This practice is essential to prevent cross-contamination and reduce the risk of wound infection, particularly in patients with compromised immune systems or chronic wounds. The use of alcohol-based hand rubs (ABHR) is acceptable when hands are not visibly soiled, while soap and water should be used when hands are visibly dirty or after contact with bodily fluids. Importantly, glove use does not replace hand hygiene; hands must be sanitized before donning (putting on) and after removing gloves to maintain aseptic technique and ensure patient safety.Review of the admission Record, found in R59's electronic medical record (EMR), under the Profile tab, indicated that the facility admitted R59 with pertinent diagnosis including but not limited to heart failure, human immunodeficiency virus (HIV) disease, and anemia.Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/3/2025 revealed that R59 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. Further review revealed R59 had three venous/atrial ulcers present upon admission.Review of R59's Care Plan, last revised on 9/16/2025, found in R59's EMR under the Care Plan tab, indicated R59 had actual impairment to skin integrity related to an atrial wound of the left and right foot. The care plan instructed staff to keep the skin clean and dry, monitor and document the location, size, and treatment of any skin injury, and report any abnormalities to the physician.Review of the Clinical Physician Orders dated September 2025, located in the EMR under the Orders tab, revealed the following wound care orders:-09/1/2025: Arterial wound to the right foot. Cleanse the area with wound cleanser, apply skin prep to the peri-wound, paint the area with betadine, cover with an ABD pad, and roll gauze. -9/1/2025: Arterial wound to the left foot. Cleanse the area with wound cleanser, apply skin prep to the peri-wound, paint the area with betadine, cover with an ABD pad, and roll gauze.During an observation on 9/23/2025 at 12:20 PM with LPN2 and Registered Nurse (RN) 2, LPN2 did not perform hand hygiene, either by washing with soap and water or using an alcohol-based hand rub (ABHR), after changing gloves between cleaning the wounds on R59's left and right feet, treating the wounds, and applying the wound dressings.During an interview on 9/23/2025 at 12:40 PM, LPN2 acknowledged that she did not perform hand hygiene, either by washing with soap and water or using an ABHR, after changing gloves between cleaning the wounds on R59's left and right feet, treating the wounds, and applying the wound dressings.During an interview on 9/23/2025 at 12:45 PM, RN2 acknowledged that LPN2 did not perform hand hygiene, either by washing with soap and water or using an ABHR, after changing gloves between cleaning the wounds on R59's left and right feet, treating the wounds, and applying the wound dressings. Upon inquiry, RN2 stated that failure to perform hand hygiene in between glove changes during wound care may lead to an increased risk of wound infection.