

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115110	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER Buckhead Center for Nursing & Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 54 Peachtree Park Drive NE Atlanta, GA 30309	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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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 observations, staff interviews, and record review, the facility failed to maintain food storage, preparation, and service areas in a sanitary manner by failing to remove food products that exceeded their use-by date and by failing to maintain kitchen floors and equipment in a clean condition to prevent the accumulation of food debris and other contaminants. This deficient practice had the potential to affect 136 out of 148 residents who received nourishment from the facility kitchen. Findings include: A policy addressing the storage, preparation, and service of meals was requested during the survey but was not provided by the facility. Review of the facility document titled Cleaning and Sanitizing stated, Cleaning and sanitizing are essential to keep food safe. Dirty equipment or food contact surfaces can result in food becoming contaminated through biological, chemical, and/or physical hazards. The document further stated that kitchen equipment and surfaces should be cleaned after each use, when contamination occurs, when work is interrupted, and before changing food types. During the initial kitchen tour on 07/13/2026, at 9:00 AM, accompanied by the Dietary Manager (DM), a large container labeled corn meal was observed in the dry storage room with a dried, soiled towel resting on top. When asked about the towel, the DM immediately removed it and rolled the container out of the dry storage area. The DM was later observed emptying the contents of the container and cleaning it. A deep freezer located in the dry storage room, containing ice cream and frozen nutritional supplements, was observed with frozen accumulations of spilled liquid and soiled surfaces on the interior floor. The DM acknowledged the appearance of the spill and stated the freezer was cleaned every two weeks. A reach-in refrigerator contained a bag of coleslaw mix (cabbage and carrots) labeled with a use-by date of 07/03/2026. The cabbage appeared wilted, and moisture was present in the bottom of the bag. When asked about the product, the DM removed it for disposal and stated it had been overlooked. Further observation of the kitchen revealed accumulations of brownish-black debris along the baseboard beneath the handwashing sink and beneath and behind the fryer, range, oven, three-compartment sink, and prep sink. During meal tray service on 07/13/2026, at 12:10 PM, the DM was asked about the flooring being soiled and uneven and he expressed that they did clean it multiple times daily, but that the unevenness did make it harder to prevent pooling. Observation of a vent above the three-compartment sink on 07/13/2026, at 12:20 PM, revealed excessive dust. The DM was asked about the vent, and he stated that it was the responsibility of the maintenance team. During an interview with the Maintenance Director on 07/15/2026, at 3:34 PM, he confirmed that he was not aware of a vent in the kitchen, but that he would look into it.		

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: 115110 If continuation sheet Page 1 of 13

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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. Based on resident and staff interviews, record review, and review of the facility's policy titled, Comprehensive Care Plan, the facility failed to ensure the right to participate in their care planning process for two of 41 residents (R) (R101 and R30). The deficient practice placed the residents at risk of not being aware of the goals and outcomes of their care and for their care plan not to be person centered. Findings include: Review of a facility policy titled Comprehensive Care Plan dated October 2025 indicated, .It is the policy of this facility to develop and implement a person-centered care plan for each resident, consistent with resident rights. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to. The attending physician or non-physician practitioner designee involved in the resident's care plan. A registered nurse with responsibilities of the resident. A nurse aide with responsibility for the resident. A member of the food and nutrition services staff. The resident and the resident's representative, to the extent possible. 1. Review of R101's admission Record located under the Profile tab of the electronic medical record (EMR) indicated that the resident was admitted to the facility with a diagnosis of but not limited to osteoarthritis, unspecified. Review of R101's quarterly Minimum Data Set (MDS) located under the MDS tab of the EMR dated 05/20/2026, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which revealed the resident was moderately cognitively impaired. Review of a document provided by the facility titled Care Plan Report indicated R101 attended a care plan meeting on 12/02/2025. There was no documentation R101 attended the March 2026, or June 2026, care plan meetings. Review of R101's clinical records revealed the record failed to contain evidence that the resident and/or her representative were invited to her quarterly care conferences. During an interview on 07/13/2026, at 8:49 AM, R101 stated she did not remember being invited to participate in her quarterly care conferences. During interview on 07/15/2026, at 9:16 AM, the current Social Services Director (SSD) stated the MDS Coordinator provided her with a calendar, and she would then schedule the care plan meetings. During an interview on 07/16/2026, at 11:34 AM, Administrator 1 stated all residents and/or their representatives were to be invited on a quarterly basis. The Administrator stated residents had the right to participate in their quarterly care conferences, so the resident was able to make decisions on their own healthcare. 2. Review of R30's admission Record located in the EMR under the Profile tab, revealed R30 was admitted to the facility with diagnoses including but not limited to chronic kidney disease, stage 3, type 2 diabetes mellitus, chronic pulmonary edema, lymphedema. Review of R30's annual MDS with a date of 06/22/2026, located in the EMR under the MDS tab, revealed the resident had a BIMS score of 15 out of 15, which indicated R30 was cognitively intact. During an interview on 07/13/2026, at 11:39 AM, R30 indicated that the facility does not have a quarterly care plan meeting every three months. R30 stated, .they've done that once or twice, but they don't do that every three months. During an interview with Licensed Practical Nurse (LPN) 5 on 07/14/2026, at 12:17 PM, revealed she attended care plan meetings which were held in R30's room, however she was unable to verify when the last meeting was held. During an interview with Social Services Director (SSD) on 07/14/2026, at 1:18 PM, it was revealed she was asked to provide verification of care plan meetings that included resident participation. The facility provided a copy of a letter of invitation for participation in an interdisciplinary care plan meeting for 04/03/2024. No additional documentation of a care plan meeting was provided.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and review of facility policies titled, Transfer and Discharge and Bed Hold Prior to Transfer, the facility failed to provide the resident or resident representative with a written notice of transfer or discharge and failed to provide a notice of bed-hold policy and return before transfer to hospital for one of four residents (R) (R175) reviewed for discharge. Findings include: Review of the facility's policy titled, Transfer and Discharge, with a revised date of March 2025, indicated, .The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. Review of the facility's policy titled, Bed Hold Prior to Transfer, with a revised date of March 2025, indicated, .It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold practices both well in advance, and at the time of, a transfer for hospitalization. Review of R175's admission Record located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility with diagnoses including but not limited to seizures, high blood pressure, type two diabetes mellitus, blood clot of lower extremity, and major depressive disorder. Review of R175's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/01/2025, in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of seven out of 15, indicating the resident was severely cognitive impaired. Review of R175's EMR revealed the resident was transferred to the hospital for evaluation on 01/05/2026 and on 01/10/2026. There was no documentation to indicate written notice of transfer was provided to the resident or their representative. A notice of bed-hold policy was provided on 01/10/2026. An interview with the Administrator on 07/15/2026, at 2:30 PM, confirmed the facility did not provide a written notice of transfer prior to R175's transfer to the hospital on [DATE] or 01/10/2026, and the facility failed to provide a notice of bed-hold policy for 01/05/2026.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. Based on staff interviews, record review, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure the Minimum Data Set (MDS) assessments were transmitted within the timeframes specified in the RAI manual for one of three residents (R) (R76) whose MDS submissions were reviewed. This failure had the potential for the discharged resident not to be able to receive services elsewhere because Medicare was not aware of the discharge status and for an inappropriate payment for services to the facility. Findings include: Review of the October 2025 RAI Manual revealed on page 2-39:09. Discharge Assessment-Return Not Anticipated . Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days). Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days). Consists of demographic, administrative, and clinical items . Review of R76's electronic medical record (EMR) Progress Notes tab revealed the following: On 05/01/2026, at 6:04 PM, Nurses Note Late Entry: Note Text: Resident LOA [Leave of Absence] w/GF [with girlfriend]. On 05/02/2026, at 10:05 PM, Nurses Note Late Entry: Note Text: Resident was not present in the facility at the time scheduled medications were due; medications were not administered. 05/02/2026, at 1:53 PM, Nurses Note Text: Resident left facility yesterday at approximately 1800 (6:00 PM) and has not returned to facility at this time. Attempts made to contact closest family member/responsible party; however, number on file is not working. Resident was last observed alert and oriented with no signs or symptoms of acute distress noted prior to departure . Per review of R76's EMR, as of 07/14/2026, R76 had not returned to the facility. Review of R76's EMR MDS tab revealed the last MDS submitted was a quarterly assessment on 04/15/2026. There was no documented evidence that a discharge assessment had been completed even though the resident had not been in the facility since 05/01/2026. During an interview on 07/14/2026, at 2:48 PM, the Regional MDS Coordinator (RMDSC) reviewed R76's progress notes and stated, The progress note says LOA. The RMDSC reviewed the EMR Census tab and stated, LOA as of 5/7 then reviewed the EMR MDS tab and stated, It's [discharge assessment] missing. The last MDS was a quarterly sent in on 04/15/2026. The RMDSC stated she started a discharge return not anticipated MDS assessment during the interview. During an interview on 07/16/2026, at 2:50 PM, the Administrator stated an expectation that MDS discharge assessments would be submitted timely. During an interview on 07/16/2026, at 2:55 PM, the Regional Director of Clinical Operations reviewed R76's MDS screen in the EMR and confirmed the discharge assessment was not completed timely. During an interview on 07/16/2026, at 3:36 PM, the Regional Director of Compliance stated, The facility uses the RAI Manual in lieu of policies.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, staff interviews, record review, and review of the facility policies titled, Comprehensive Care Plan and Proper Use of Bed Rails, the facility failed to develop and implement a comprehensive person-centered care plan for the two of 44 sampled residents (R) (R5 and R154). Specifically, the care plan did not include measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs specifically related to the resident's use of bed rails and activities. This failure had the potential to affect the accuracy and complexity of resident care. Findings include: Review of the facility policy titled Comprehensive Care Plan, reviewed/revised October 2025, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and meet professional standards of quality. Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent and trauma-informed care as indicated. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Review of the facility policy titled Proper Use of Bed Rails, implemented 10/01/2022, revealed: Ongoing Monitoring and Supervision, 1. The facility will continue to provide necessary treatment and care to the resident who has bed rails in accordance with professional standards of practice and the resident's choices. This should be evidenced in the resident's records, including their care plan, including, but not limited to, the following information: . 1. Observation of R5's bed on 07/13/2026, at 10:42 AM, revealed a low-air-loss air mattress with bilateral assist rails towards the head of the bed. Observation on 07/15/2026, at 2:50 PM, revealed R5 in the bed with the air mattress and bilateral assist rails. Review of R5's electronic medical record (EMR), under the Care Plan' tab, revealed a care plan created on 04/10/2026, for a focus of: Bed Mobility indicated the resident requires extensive assistance times one to two staff for moving in bed. Another care plan indicated R5's is at risk for a fall related to: late effects of pontine strokes, antidepressant medication. There was no documentation of the use of bed rails being an intervention on the resident care plan. During an interview on 07/16/2026, at 2:58 PM, the Administrator stated bed rails should be care planned. 2. Review of R154's EMR, located under the MDS tab, revealed the quarterly MDS with an Assessment Reference Date (ARD) of 06/22/2026, revealed an admission date of 04/20/2026; BIMS score of 2 out of 15, indicating a severe cognitive impairment; diagnosis of encephalopathy, coronary artery disease, hyperlipidemia, depression, alcohol dependent with alcohol-induced persisting amnesic disorder; medications received antidepressant. Review of R154's EMR located under the Care Plan tab revealed the comprehensive care plan that does not include a focus on the care plan for activities. During an interview on 07/16/2026, at 11:15 AM, the DON stated that R154 should have an activities section of the care plan to ensure activities met the needs of the resident. During an interview on 07/16/2026, at 11:35 AM, the Activities Director (AD) stated that the care plan should include activities and the type of activities that were appropriate for that resident. The AD confirmed that R154 did not have an activities section on the care plan.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, resident and staff interviews, record review, and review of the facility policy titled, Resident Smoking, the facility failed to provide adequate supervision to ensure residents smoked safely and only in designated smoking areas for one of three residents (R) (R77) reviewed for smoking practices. The facility's failure to adequately monitor and supervise R77's smoking activities placed the resident at risk for serious injury and had the potential to jeopardize the health and safety of current residents and staff. Findings include: Review of the facility's policy titled Resident Smoking, dated December 2023, indicated under Policy: It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and nonsmoking residents. Policy Explanation and Compliance Guidelines: I. Smoking is prohibited in all areas except the designated smoking area. A 'Designated Smoking Area sign will be prominently posted . 10. All safe smoking measures will be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who will be responsible for supervising residents while smoking. Supervision will be provided as indicated on each resident's care plan . Review of R77's undated admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R77 was admitted to the facility with a diagnoses of but not limited to schizophrenia, acquired absence of the left eye, contusion of eyeball and orbital tissues of the right eye, and retinal detachment with single break of the right eye. Review of R77's annual Minimum Data Set (MDS) assessment located in the EMR under MDS tab, with an Assessment Reference Date (ARD) of 05/04/2026, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated he was moderately cognitively impaired. The MDS also indicted R77 currently uses tobacco. Review of the R77's Care Plan, initiated on 06/30/2025, located in the EMR under the Care Plan tab, revealed R77 was a current smoker with interventions that included: he would smoke only in authorized areas, would have cigarettes/lighters locked up at all times other than smoking time, smoking education was provided to resident about not smoking in the facility, and violation of smoking rules or disregard for safety rules may result in revocation of smoking privileges. Review of R77's Smoking Evaluation, dated 09/25/2025, located in the EMR under the Assmnts [assessments] tab, revealed R77 was safe to smoke with supervision and had to wear an apron for safety. Review of R77's Behavior Note, dated 05/24/2026, located in the EMR under the Prog [Progress] Notes tab, revealed Licensed Practical Nurse (LPN) 7 informed R77 sister via telephone that R77 was observed smoking in the facility lobby and that it was a serious violation that could result in the issuance of a notice of discharge in accordance with facility policy. Review of R77's Smoking Evaluation, dated 06/05/2026, located in the EMR under the Assmnts tab, revealed R77 was safe to smoke with supervision and had to wear an apron for safety. Review of R77's Smoking Evaluation located under the Assessments tab in the EMR revealed there were only two smoking evaluations completed between September 2025 and June 2026. Review of R77's Physician's Orders, started on 06/06/2026, and discontinued on 06/28/2026, located in the EMR under the Orders tab, revealed an order for Nicotine Transdermal Patch 24 hour 7 milligrams (MG)/24 hour (nicotine) apply one patch transdermally one time a day for 28 days and remove per schedule. Review of R77's Medication Administration Record (MAR), dated June 2026, located in the EMR under the Orders tab, revealed R77 refused the nicotine patch on 06/06/2026, 06/08/2026, 06/14/2026, 06/16/2026, 06/20/2026, and 06/28/2026. Review of R77's Encounter Note, dated 06/08/2026, located in the EMR under the Prog Notes tab, revealed the Nurse Practitioner (NP) offered smoking cessation and ordered (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nicotine patch. Review of R77's Social Services Progress Note, dated 06/18/2026, located in the EMR under the Prog Notes tab, revealed a referral was sent to a nursing home for potential admission and transfer. Review of R77's Encounter Note, dated 06/18/2026, located in the EMR under the Prog Notes tab, revealed the NP offered smoking cessation to R77 and he declined the offer for smoking cessation. Review of R77's Behavior Note, dated 07/08/2026, located in the EMR under the Prog Notes tab, revealed R77 was seen smoking in the downstairs lobby restroom during the shift. Registered Nurse (RN) 1 informed R77 that smoking in the restroom was prohibited and was educated on the smoking policy and associated safety risks. Review of R77's General Progress Note, dated 07/09/2026, located in the EMR under the Prog Notes tab, revealed the Administrator informed the Ombudsman regarding R77 smoking in the building and was noncompliant with smoking in the designated smoking area. Review of R77's Nurses Note, dated 07/10/2026, located in the EMR under the Prog Notes tab, revealed R77's bedside table was observed with cigarette ashes and burn marks on it. RN1 educated him about maintaining a safe environment and safety concerns were reported to appropriate staff. Review of R77's Nurses Note, dated 07/13/2026, located in the EMR under the Prog Notes tab, revealed the Administrator was informed by Licensed Practical Nurse (LPN) 5/Unit Manager (UM) on the second floor, noted that R77 was found smoking in the bathroom on the first floor by the Dialysis Nurse. R77 denied smoking in the bathroom although cigarette smoke could be smelled on him. R77 was reminded of the facility policy and the Administrator was notified. Review of R77's General Progress Note, dated 07/13/2026, located in the EMR under the Prog Notes tab, revealed the Administrator emailed the Ombudsman again regarding R77 smoking in the building. Observation and interview on 07/14/2026, at 3:39 PM, with R77 by the elevator in the first-floor lobby, revealed he was sitting in a wheelchair with no burn marks on his clothing. R77 stated he had been caught smoking in the building when he was first admitted to the facility, and staff confiscated his lighter. R77 also stated that activity staff and/or certified nursing aides (CNAs) bought him a lighter and cigarettes. R77 indicated he was informed not to smoke in the building after he was caught a long time ago. Continued observation revealed the receptionist was seated at the front desk observing R77 while in the lobby area. During an interview on 07/14/2026, at 3:45 PM, Administrator 1 confirmed that the May 2026 unsafe smoking incident was not reported to her by staff, but staff reported to her within the last few weeks that R77 was seen smoking in the bathroom on the first floor. Administrator 1 stated the Social Services Director (SSD) tried to find placement for him at another facility, did not provide R77 with a 30-day discharge notice, and that she informed the Ombudsman of the incident on 07/09/2026. Administrator 1 indicated that R77 had been placed on one-to-one monitoring on 07/14/2026, due to staff reporting that he was observed smoking in the first-floor bathroom on 07/13/2026. Administrator 1 verified that either she or the Director of Nursing (DON) had investigated the July 2026 smoking incidents that were reported to her in July 2026, and did not determine who brought the cigarettes and a lighter to R77 at the facility. Administrator 1 stated the Ombudsman had not responded to her requests for assistance with R77's smoking incidents yet. During an interview on 07/14/2026, at 4:07 PM, the SSD confirmed it was reported to her that R77 had smoked in the building and she tried to find placement for him at another facility, but admission was denied. The SSD stated she completed a smoking evaluation on R77 and he was safe to smoke with supervision and an apron due to visual impairments on 06/05/2026. The SSD verified that she did not issue R77 a 30-day discharge notice after the smoking incidents. The SSD indicated that she did not know who was completing the prior smoking assessments, but they were due quarterly to determine if residents were safe to smoke. The SSD also indicated R77 did not have a behavior plan in place but had refused to take his antipsychotic medications recently and was admitted for a five day stay at a behavioral (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	health hospital for medication management due to explosive verbally aggressive behaviors. The SSD verified R77 did not have a behavior plan in place. During an interview on 07/14/2026, at 4:24 PM, Activities Assistant (AA) 2 stated she had to take away a lighter from R77 once in June 2026, while he was smoking in the designated smoking area, because the activities staff lit their cigarettes and residents were not supposed to have lighters. AA2 also stated she reported the incident to the Activities Supervisor but did not document it. AA2 indicated that activities staff did not purchase/provide cigarettes to the resident and the family had to supply R77 with them. During an interview on 07/14/2026, at 4:28 PM, the Activity Supervisor confirmed that she confiscated a lighter from R77 in June 2026 and had to threaten to call the police for him to give it to her and she reported it to the Administrator, but she did not document the information anywhere as she did not know how to use the EMR yet. The Activity Director stated she was not aware who bought him cigarettes and lighters, but activities staff were not doing it for any of the residents. The Activity Director stated that the nurses dispensed two cigarettes per smoke break to the residents and then the activity staff and/or CNAs would light their cigarettes in the designated smoking area. During an interview on 07/14/2026, at 5:49 PM, Licensed Practical Nurse/Unit Manager (LPN/UM)7 stated that a CNA reported that she saw R77 smoke in the bathroom on the first floor, prior to the smoke break at 8:00 PM on 05/24/2026. LPN/UM7 also stated she reported the incident to the former DON. LPN/UM7 stated the resident's cigarettes were locked up on the medication cart in the medication room and two were dispensed to the residents prior to smoke breaks, and the CNA or activity staff would light the cigarettes in the designated smoking area. During an interview on 07/14/2026, at 5:41 PM, the Dialysis Nurse confirmed she observed R77's wheelchair outside of the first-floor bathroom, smelled smoke, and saw cigarette ashes after he exited the bathroom on 07/08/2026, and 07/13/2026. The Dialysis Nurse stated she reported the incidents to LPN7/UM on the second floor and Registered Nurse (RN) 1. During an interview on 07/15/2026, at 8:39 AM, LPN/UM7 on the second floor, stated she was informed by the Dialysis Nurse on 07/08/2026 and 07/13/2026 about R77 smoking in the lobby on the first floor in the bathroom. LPN/UM7 also stated she educated R77 about the safety risks while smoking in the building and R77 denied smoking in the building. LPN/UM7 indicated R77 would not let her search him, and she could not take away his smoke breaks because both were resident rights violations. LPN/UM7 stated the nurses on each floor kept the residents' cigarettes in the medication cart and gave them two cigarettes prior to the smoke break, and then the staff that took the residents on the smoke break would light their cigarettes in the outside designated smoking area. During an interview on 07/15/2026, at 8:46 AM, the DON stated she expected the staff to complete a progress note and notify the Physician, Psyche Provider, family, her, and the Administrator when R77 was found smoking in the building or had cigarettes and lighters on him. The DON also stated that it was unsafe to smoke in the building because it could start a fire. During an interview on 07/15/2026, at 9:13 AM, RN1 revealed he did not report the smoking incident to the DON or the Administrator on 07/08/2026, because he thought the Dialysis Nurse reported it to administration. RN1 indicated he educated R77 on the smoking policy, did not offer smoking cessation, or increased monitoring of R77. RN1 confirmed that he had not tried to find out who was buying cigarettes and lighters for him and bring them to him at the facility, although he had seen R77's son and sister visit him. RN1 stated that the resident's cigarettes used to be located at the receptionist desk and locked in a room, but cigarettes were disappearing, so they changed it to keeping the cigarettes on the floor where the resident resided, which were locked up on the medication cart. RN1 verified that R77 did not have a behavior plan in place but his behaviors were being monitored due to being verbally aggressive.		

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NAME OF PROVIDER OR SUPPLIER Buckhead Center for Nursing & Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 54 Peachtree Park Drive NE Atlanta, GA 30309	
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observations, staff interviews, record review, and review of the facility policy titled, Proper Use of Bed Rails, the facility failed to ensure assessments included attempted alternatives with documented failures to bed/side rail or assist rail usage prior to the installation and use of rails for one of one resident (R) (R5) reviewed for bed/side rails out of a total sample of 44 residents. This failure had the potential to increase the risk of resident accidental entrapment or injury. Findings include: Review of the facility policy titled Proper Use of Bed Rails, implemented 10/01/2022, revealed: Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails. under Policy Explanation and Compliance Guidelines: Resident Assessment. 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. 3. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include: .6. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. Review of R5's admission Record from the electronic medical record (EMR) Profile tab, revealed a facility admission with medical diagnoses that included but not limited to hemiplegia and hemiparesis following a cerebral infarct (stroke), type II diabetes with polyneuropathy, spinal stenosis, and muscle weakness. Observation of R5's room on 07/13/2026, at 10:42 AM, revealed the bed had a low air loss air mattress with bilateral upper bed area assist bars. During an interview on 07/15/2026 at 2:50 PM, R5 was in bed with the bilateral upper assist bars and air mattress. R5 stated he used the assist bars. When asked if anyone from the facility had discussed with him the risks of having assist bars, R5 stated, No. When asked if anyone from the facility had discussed the benefits of having assist bars, R5 responded, No. When asked if the facility had ever tried something other than the assist bars, like perhaps a trapeze bar, R5 stated, No. Review of R5's Bed Rail Evaluation, dated 04/09/2026, revealed a statement that the resident requested bed rails on the day of admission; and: .2. Interventions 2. Select all interventions that apply to this resident, a. Lower the bed to the floor. c. Provide frequent staff monitoring at night. e. Visual and verbal reminders to use the call bell R5's name was typed into the Resident/Responsible Party Signature and Date with no date, however the form did not document advisement of risks/benefits of rail use or informed consent for rail use. During an interview on 07/16/2026, at 11:45 AM, regarding the Bed Rail Evaluation, Regional Director of Compliance (RDC) confirmed the resident name typed at the bottom of the form was not a signed informed consent for bed rails. In a follow up interview on 07/16/2026, at 3:05 PM, the RDC completed a final review of the Bed Rail Assessment and confirmed the Resident/Representative Name Date line was not signifying informed consent. The RDC stated an expectation that there should be informed consent for bed rails and documented attempted alternatives and reason for failure.		

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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. Based on observations, staff interviews, record review, and review of the facility policy titled, Enhanced Barrier Precautions, the facility failed to ensure infection prevention and control practices were implemented for two of 71 sampled residents (R) (R12 and R140). Specifically, the facility failed to ensure appropriate personal protective equipment (PPE) was worn by staff while performing activities of daily living (ADLs) for a vulnerable resident (R12) and failed to properly disinfect a shared glucometer between resident uses. This failure has the potential to expose residents to cross-contamination and the transmission of infectious organisms, including bloodborne pathogens. Findings include: Review of the facility policy titled Enhanced Barrier Precautions date reviewed/revised March 2024 states under Policy: It is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The policy defines EBP as an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. 2. Initiation of Enhanced Barrier Precautions: .b. An order for enhanced barrier precautions will be obtained for resident with any of the following: . i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. ii. Infection or, . colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply. 4. High-contact resident care activities include: a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linen f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes h. Wound care: any skin opening requiring a dressing . 9. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 1. Review of the Face Sheet found under the Profile tab of the electronic medical record (EMR) revealed R12 was originally admitted with diagnoses of but not limited to quadriplegia, chronic infections, pressure injuries, neuromuscular dysfunction of bladder, and malnutrition. Further review of the EMR revealed the resident's plan of care, found under the Care Plan tab, revealed the resident has an ADL care deficit along with impaired mobility, staged and unstageable wounds, a catheter, and colostomy. During an observation on 01/14/2026, at 12:51 PM, Certified Nursing Assistant (CNA) 4 was observed entering and exiting R12's several times. She grabbed items from the cart and reentered the room. Further observations revealed there was a sign on R12's door indicating the resident was on EBP and staff should wear the appropriate PPE when providing care. During an interview on 01/14/2026, at 1:06 PM, CNA4 explained she was emptying R12's colostomy bag. She was then asked about the sign on the door referencing EBP, she stated that she had not worked with R12 for some time and may not be as familiar with his care as she used to be. She admitted that she had not worn the appropriate PPE while providing care to the resident. During an interview with the Director of Nursing (DON) on 07/15/2026, at 4:30 PM, she confirmed that when providing care staff should don (put on) all appropriate PPE. She was then asked where it was located and she said it should be in the resident's storage area. She was also advised that their policy states an order would be obtained for EBP, and she confirmed that they didn't usually get orders for EBP but that any resident with wounds or that fit the criteria was automatically placed under the protocol. 2. Review of the facility policy titled Glucometer Disinfection, reviewed/revised 09/12/2022, revealed under: Policy: The purpose of this (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Definitions: Cleaning is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with detergents or enzymatic products. Disinfection is a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects. Policy Explanation and Compliance Guidelines: 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. 2. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected then the meter will not be used for multiple residents. 3. The glucometers will be disinfected with a wipe pre-saturated with an EPA (Environmental Protection Agency) registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. 4. 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. Review of the facility provided brand name glucometer Quality Assurance/Quality Control (QA./QC) Reference Manual revealed on page 19: Guidelines for Cleaning And Disinfecting The brand name Meter: To minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed as recommended in the instructions below. The brand name Blood Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient, . diabetes testing company has tested and validated the durability and functionality of the brand name meter with the most commonly used EPA-registered wipes. diabetes testing company recommends using these wipes to clean and disinfect the name brand meter: During an observation of blood glucose testing for R140 on 07/15/2026, at 3:50 PM. LPN 8 opened top drawer of the medication cart revealing two glucometers (one on top of the other). LPN8 removed the top one and laid it on the top of the medication cart, along with a lancet (safety device to cause a drop of blood for testing), alcohol wipe, and a jar of test strips. Upon entering the room, LPN8 verbally noted she needed to program the feeding pump for a flush because R140 got a flush with every finger stick. LPN8 laid the glucometer on R140's blanket, holding the other items; then picked up the glucometer and walked to the window side of the bed, gloved, laid the glucometer on a pillow (in case) along with the alcohol wipe package, removed a strip from the bottle, laid the bottle on the sheet (which rolled onto the blanket), wiped R140's finger with an alcohol wipe and laid the wipe on the blanket, lanced the finger and laid the lancet on the table; applied the blood drop to strip and placed the glucometer back onto the bedding. LPN8 disposed of the strip and used lancet, read the glucometer and put the strip bottle and glucometer into scrub top pocket; exited the room back to the medication cart, used hand sanitizer and pulled the strip bottle and glucometer from her pocket, placing them on the medication cart top. LPN8 retrieved an alcohol wipe from the cart drawer, gloved, and cleaned the glucometer with the alcohol wipe. Upon questioning at 3:56 PM, LPN8 verbally confirmed she was using an alcohol wipe. LPN8 then laid the glucometer on top of the medication cart, opened the top drawer and placed the uncleaned strip bottle into the drawer, removed her gloves and started typing on the laptop, checked and stated the glucose reading did not require any insulin coverage, then opened the cart drawer and laid the glucometer from the top of the medication cart on top of the other glucometer that remained in the drawer. During an interview on 07/16/2026, at 3:00 PM, the Regional Director of Operations (RDO) stated an expectation they would follow the policy for glucometer disinfection. Upon questioning on where the glucometer and items should be placed, the Regional Director of Clinical Services (RDCS)1 stated staff was to use a barrier under it. During an (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 07/16/2026, at 4:15 PM, LPN8 confirmed she had used an alcohol wipe to disinfect the glucometer. LPN8 stated she had received education, but she knew that was the wrong thing but used it anyway, perhaps because she had been nervous. LPN8 also stated anyone in the facility that had a blood borne pathogen and received blood glucose checks had their own glucometer and they didn't share.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interview, the facility failed to maintain a safe and functional kitchen environment. The facility failed to ensure the kitchen flooring was maintained in a manner that provided stable placement of equipment, resulting in the potential for equipment instability and increasing the risk of staff injury while working in the kitchen. Findings include: During the initial kitchen tour with the Dietary Manager (DM) on 07/13/2026, at 9:00 AM, observation of the tile floor revealed multiple uneven areas. An area near the prep sink had water pooling in the grout. Other areas including uneven tiles at the entrance of the dishwashing room, near the handwashing sink and under and around the fryer, range and ovens. During a subsequent visit to the kitchen on 01/13/2026, at 11:40 AM, under one of the front legs of the convection oven, were multiple folded and stacked cardboard pieces. The DM was asked about the pieces of cardboard, and he confirmed that it was there to stabilize and ensure the oven sat evenly. The DM was asked if maintenance and the administration were aware and he stated that they were, but he was not sure what the plan was to fix the concerns. During an interview with the Maintenance Director on 07/15/2026, at 3:34 PM, he confirmed that he was aware of the concern with the flooring and the oven placed on the cardboard and that corporate was working to resolve the concern.		