STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115587	A. Building B. Wing	03/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buchanan Healthcare Center	144 Depot Street Buchanan, GA 30113

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33548 Based on observations, staff interviews, and review of the facility policy titled, Wheelchair Cleaning and Maintenance Policy, the facility failed to ensure one resident's (R) (R18) wheelchair was maintained in a sanitary manner from 32 wheelchairs actively used by residents. Findings include: Review of the facility policy titled Wheelchair Cleaning and Maintenance Policy revealed under Purpose: to ensure resident wheelchairs are maintained in a clean and safe condition, in alignment with the facility's infection prevention and safety practices. Policy statement revealed: The facility is committed to ensuring all resident wheelchairs are clean, functional, and appropriate for continued use. Cleaning and maintenance practices are based on resident need, equipment condition, and clinical indication. Procedure revealed: General Cleaning - wheelchairs are cleaned as needed to address visible soiling or based on clinical observation. Review of R18's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score was 12, indicating her cognition was moderately compromised. The MDS also revealed that R18 used a manual wheelchair while in the facility. During visits with R18, she was alert, orientated, and able to make her needs known. Observation on 3/28/2025 at 9:20 am of R18 revealed she was sitting in her wheelchair in her room finishing her breakfast meal. Observation of R18's wheelchair revealed that there was a build-up of dirt and debris on the metal frame as well as on the wheel spokes. Interview on 3/28/2025 at 9:20 am with R18 revealed that she does not recall if her wheelchair has ever been cleaned since she had been in the building. R18 revealed that about a month ago both arm rests were replaced due to the material being cracked and having holes. Observation on 3/29/2025 at 2:15 pm of R18's wheelchair revealed the dirt and debris on the metal frame remained. Further observation revealed a thick layer of hair wrapped around the [NAME] of the wheelchair wheels. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/30/2025 at 10:25 am with the Maintenance Director (MD), she confirmed that R18's wheelchair had a significant build-up of dirt and debris on the frame. The MD revealed that the night nurse staff were responsible for wiping down and cleaning all resident wheelchairs. The MD stated that she was responsible for the overall maintenance and condition of resident wheelchairs such as the brakes, seat cushion, and arm rests. The MD confirmed that the arm rests to R18's wheelchair had been replaced about a month ago and while working on the wheelchair she did not inspect the cleanliness. The MD revealed that if she had seen the dirt and debris at that time, she would have cleaned it. The MD revealed that nursing staff clean resident wheelchairs by using bleach wipes. The MD revealed she monitored each wheelchair monthly, checked the condition, and maintained a log for each wheelchair. The MD revealed that the facility had 32 active/working wheelchairs but had 63 wheelchairs in total in the facility. During an interview on 3/30/2025 at 10:45 am, the Director of Nursing (DON) revealed that all staff were responsible for ensuring resident wheelchairs were clean. She stated that cleaning resident's wheelchairs was not a scheduled task for nursing staff to complete. The DON revealed that the facility had a Guardian Angel program, and members of the leadership team were assigned resident rooms to review/round and the DON stated that observing resident wheelchairs should be a part of those rounds. Review of the untitled form used during Guardian Angel rounds revealed a question is the wheelchair clean. The forms dated 3/28/2025, 3/21/2025, 3/14/2025, 3/7/2025, 2/28/2025, 2/21/2025, 2/14/2025, and 2/7/2025, all indicated no issues with R18's wheelchair. Review of the maintenance documentation titled Wheelchair Audit revealed 32 wheelchairs reviewed for the condition of wheelchair pad, wheels, arm rails, and footrest.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35062 Based on record review and staff interview, the facility failed to complete a Significant Change Assessment for two of eight residents (R) (R5 and R29) receiving hospice services after electing hospice services. The sample size was 21 residents. Findings include: 1. Record review revealed R5 was admitted to the facility on [DATE]. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented R5 was receiving hospice services. Further review of the MDS revealed no Significant Change Assessment. Review of the Physician Orders revealed R5 was admitted to hospice services on 11/30/2024. 2. Record review revealed R29 was admitted to the facility on [DATE]. Review of the MDS revealed no Significant Change Assessment was completed for R29. Review of the Physician's Orders revealed R29 was admitted to hospice services on 3/1/2025. Interview with MDS Coordinator BB on 3/30/2025 at 10:02 am revealed she did not complete a Significant Change Assessment for residents that were placed on hospice services. She stated she had never completed a Significant Change Assessment for hospice residents in the past. Review of the facility matrix revealed eight residents were receiving hospice services within the facility.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 35180 Based on observations, staff interviews, record review, and review of the facility policies titled, Administering Medications through an Enteral Tube and 'facility name' Healthcare Policy, the facility failed to ensure that one of one resident (R) (R29) sampled received adequate hydration via the gastrostomy tube (G-tube-feeding tube). Findings include: Review of the facility policy titled Administering Medications through an Enteral Tube, revised November 2018 revealed under Preparation revealed: .1. Verify that there is a physician's medication order for this procedure. A further review revealed under Equipment and Supplies: .12. Administer medication by gravity flow. Review of the facility policy titled 'facility name' Healthcare Policy dated 2/18/2025 revealed: 'name of facility' will follow CMS (Centers for Medicare and Medicaid Services) Regulations and Nursing Standards of Practice for Wound Care/Care Plans/Accidents/Physician Orders/Restraints/Siderails/Oxygen Care and Administration/Medication Administration/Enteral Feeding (nutrition through tube inserted into abdomen into gastrointestinal tract)/Catheter Care and Maintenance. A review of the physician's orders dated 2/18/2025 revealed an order to administer 100 cc (milliliters) of water via R29's G-tube with 100 cc before and after each bolus feeding, five times per day. An observation on 3/29/2025 at 9:48 am of R29's bolus feeding revealed that Licensed Practical Nurse (LPN) AA collected the ordered Jevity (enteral feeding) 1.5 (1) carton, a 60-cc syringe, and a cup of water. LPN AA obtained the resident's permission to enter the room and administer the bolus (all at once) feeding/fluids. LPN AA auscultated (listened) for bowel sounds using a stethoscope, and LPN AA verified G-tube placement via assessment of residuals (tube feeding left in stomach). No residuals were noted. Using the syringe and plunger, LPN AA drew 30 cc of water into the 60-cc syringe. She then administered 30 cc of water utilizing the plunger, clamped the tubing, and removed the syringe. LPN AA removed the plunger from the syringe and reattached the syringe to the end of the tubing, unclamped the tubing, and administered one carton of Jevity 1.5 via gravity. LPN AA then clamped the tubing, removed the syringe from the tubing, and reattached the plunger. LPN AA then drew another 30 cc of water into the 60-cc syringe using the plunger. She unclamped the tubing, administered 30 cc of water utilizing the plunger, clamped the tubing, and removed the syringe. During an interview with LPN AA on 3/29/2025 at 2:15 pm, she stated she looked at the physician's order before administering R29's feeding bolus, but she did not check to see how much water she was supposed to administer to R29. LPN AA acknowledged she gave 30 cc of water before and after R29's bolus instead of the ordered 100 cc of water. During an interview with the Director of Nursing (DON) on 3/29/2025 at 2:25 pm, she confirmed that LPN AA administered R29 30 cc of water instead of the 100 cc of water ordered by the physician. The DON added she expected the nursing staff to verify and administer all orders per physician orders.