STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115682	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkside at Budd Terrace Operating Company LLC	1833 Clifton Road, NE Atlanta, GA 30329

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, and record review, the facility failed to provide Activities of Daily Living (ADL) care, specifically bathing services, in accordance with the residents' needs and the facility's established schedule for three (Residents (R) 306, 76 and 299) of 12 residents reviewed for bathing in the sample of 63 residents, placing the residents at risk for poor hygiene and decreased quality of life.Findings include: 1.Review of R306's electronic medical record (EMR) admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE] following a hospitalization related to a rotator cuff tear and diagnoses of right knee pain, quadriplegia, muscle wasting, and chronic pain syndrome. Review of R306's EMR admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/10/2026 with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R306 was cognitively intact. Review of R306's Care Plan under the Care Plan tab of the EMR revealed R306 required staff assistance with Activities of Daily Living (ADLs) due to a self-care performance deficit, including bathing. Review of R306'sshower documentation located under the Task tab of the EMR, revealed the resident received assistance with bathing, ranging from physical assistance to total dependence, on the following dates: 02/07/2026, 02/10/2026, 02/25/2026, 03/04/2026, and 03/05/2026. There was no documentation to indicate the resident received showers in accordance with the facility's established schedule on other assigned shower days, and there was no documented refusal or clinical justification for the missed showers. Interview on 03/27/2026 at 8:45 AM, Registered Nurse (RN) 1 stated the facility's practice was to offer showers based on room assignment, with even-numbered rooms scheduled on specific days and odd-numbered rooms on alternate days. RN1 confirmed R306 resided in an even-numbered room and was expected to receive showers in accordance with that schedule. RN1 further stated that Certified Nursing Assistants (CNAs), including agency staff, were responsible for providing showers; however, agency CNAs did not have access to document care in the EMR and were expected to report completed care to the licensed nurse or oncoming shift. RN1 acknowledged this process was not consistently followed, which may have resulted in incomplete documentation and uncertainty as to whether showers were provided as scheduled. 2. Review of R299's admission Record, dated 03/23/2026 in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of history of stroke and epilepsy. (continued on next page)

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R299's quarterly MDS with an ARD of 02/27/2026 in the EMR under the MDS tab revealed a BIMS score of four out of 15, which indicated the resident was severely cognitively impaired. The MDS indicated the resident was totally dependent upon staff to complete her bathing/showering. Review of R299's ADL Care Plan dated 02/27/2026 in the EMR under the Care Plan tab indicated, Two staff members provide physical care with personal hygiene, bathing, dressing, and grooming. Review of R299's Point of Care (ADL/bathing documentation) dated 02/25/2026 through 03/25/2026 in the EMR under the POC tab revealed the resident was to be bathed twice weekly on Wednesdays and Saturdays. The documentation indicated R299 had been bathed on 02/25/2026, 02/28/2026, 03/11/2026 and 03/14/2026 (only four times in the past 30 days). 3. Review of R76's admission Record in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of muscle wasting and atrophy. R76 was discharged from the facility on 03/11/2026. Review of R76's admission MDS with an ARD of 03/04/2026 in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident required moderate assistance from staff to complete his bathing/showering. Review of R76's Care Plan revealed no care plan related to bathing. Review of R76's Point of Care (ADL/bating documentation) dated 02/25/2026 through 03/11/2026 in the EMR under the POC tab, revealed no documentation to indicate when or how often the resident was to be bathed. The record indicated no evidence that R76 had been assisted with bathing during his entire admission to the facility. During an interview on 03/27/2026 at 12:37 PM, the Director of Nursing (DON) stated that her expectation was that residents were to be assisted with bathing according to their preferences and plan of care and bathing (or refusal to bathe) was to be documented in the resident's record. The DON confirmed that documentation was lacking to indicate both residents had been bathed.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and facility policy review, the facility failed to provide an ongoing activity program to meet the individual interests and needs to enhance the quality of life for two of two residents (Residents (R) 349 and R299) reviewed for activities out of a total sample of 63 residents. This deficient practice had the potential to negatively affect the quality of life for the affected residents. Findings include: Review of a facility's policy titled Activities dated April 2025 indicated, . It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. 1. Review of R349's electronic medical record (EMR) admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R349's EMR annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/20/2025 located under the MDS tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which revealed that the resident was moderately cognitively impaired. Review of R349's EMR Care Plan located under the Care Plan tab dated 10/22/2024 indicated R349 continues to engage in group (Bingo and travel/documentary videos) and self-directed/1:1 (one to one) activities in his room. Interacts with other residents, staff, family and friends daily. Will continue plan of care. Date Initiated: 07/26/2024, Revision on: 10/22/2024. Review of R349's EMR Progress Notes located under the Prog (Progress) Notes tab failed to contain evidence that the activities department conducted 1:1 activities with the resident or if the resident participated in any group activity programs during the assessment period. During an interview on 03/24/2026 at 1:58 PM, the Activity Director (AD) confirmed there was no documentation to support that R349 participated in any activities. The AD confirmed there were no quarterly activity assessments completed for R349. The AD stated it was important to do the assessments for a resident since the facility can determine if the resident should be offered other activity preferences if there was a decline in activity participation. 2. Review of R299's admission Record in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of history of stroke and epilepsy. Review of R299's quarterly MDS with an ARD of 02/27/2026 in the EMR under the MDS tab revealed a BIMS score of four out of 15, which indicated the resident was severely cognitively impaired. Review of R299's Activities Care Plan dated 02/27/2026 in the EMR under the Care Plan tab indicated, I am dependent on staff for assistance with activities, sensory stimulation and social interaction related to impaired cognitive function and physical limitations.I need increased engagement and social interactions with staff, family, and activities as desired in milieu (including) Devotional Service/Music Listening/Videos/Movies.need socialization with peers and/or interests. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions included Provide opportunities for socialization with peers as desired by resident; Provide resident with individual music listening gospel and jazz; Provide Resident with opportunities to choose genres she would like to listen to and encourage her to sing/vocalize along; Resident requires assistance using the TV remote to find programs of interest, jazz radio station and with accessing telephone. Face Time Telephone calls as scheduled with mother. Provide opportunities for scheduled Chaplain visits. Review of R299's most recent Activities assessment dated [DATE] in the EMR under the Assessment tab indicated, Resident per annual review involved in 1:1 visits for wellness, reminiscent, orientation, inspirational reading, seasonal decorations and music listening. Resident continues to interact with staff, mother, listen to music and engage in conversations. Scheduled out of room group time not accomplished.Resident continue to respond to 1:1 visits with hello, thank you, I love you, compliments and ask(s) what (is the) date? Resident not calling out as often to staff and others who pass her room door.Recommendations: 1:1 visits for wellness, reminiscent/current event discussions, inspirational reading, sensory activities aroma scents, flowers and Geri-chair rides as tolerated. Review of R299's EMR dated 01/01/2026 through 03/27/2026 revealed no documentation to indicate the resident's participation in any activity program. R299 was observed lying in bed on 03/23/2026 at 12:05 PM, on 03/24/2026 at 10:52 AM, 12:00 PM and 1:42 PM, and on 03/25/2026 at 8:31 AM and 12:07 PM. The resident was not observed to be engaged in any activities (individual, 1:1 or group) during any of the observations. During an interview on 03/24/2026 at 1:58 PM, the AD confirmed she was not able to locate any documentation to indicate R299's participation in facility or 1:1 activity programming. She confirmed R299's most recent Activities Assessment was dated 08/27/2024 and stated the assessment should have been done at least quarterly to ensure activity preferences and abilities were up to date. During an interview with the AD and Activity Assistant (AA1) on 03/24/2026 at 2:21 PM, AA1 confirmed she did not document individual resident's participation in activities. She stated she was unaware she was supposed to be documenting individual activity participation for each resident. The AA1 confirmed she did not know what R299's activity preferences were, nor was she familiar with the resident's activity care plan. During an interview on 03/27/2026 at 11:18 AM, the Administrator stated her expectation was for activities to be provided and documented according to the needs and interests of each resident. She confirmed each resident was to have an activity Assessment upon admission, quarterly and with any significant change in resident status.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, review of facility policy, the facility failed to ensure two Resident (R) R76 and R311 out of three residents reviewed for Intravenous (IV) Nutrition (i.e., Total Parenteral Nutrition (TPN)) received appropriate care related to the administration of their TPN. The facility's failure to ensure appropriate administration of TPN for R76 and R311 created the potential for these residents to experience a decline in physical status. Findings include: The facility's policy titled, Total Parenteral Nutrition (TPN) dated December 2024 indicated, The facility may administer and monitor residents receiving total parenteral nutrition (TPN) consistent with current standards of practice.Definition: Total Parenteral Nutrition (TPN) is a nutrient solution, including lipids, that is administered through a central venous access device. This solution usually consists of proteins, carbohydrates, electrolytes, vitamins, trace minerals, and lipids (as directed) . Total Parenteral Nutrition (TPN) will be administered under the direction of the ordering practitioner, in collaboration with the pharmacist and other designated individuals. Pharmacy collaboration may be with the facility's participating pharmacy and/or through a contracted infusion service, as per facility policy. Review of R311's admission Record dated 03/27/2026 in the Electronic Medical Record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD) and atrial flutter. Review of R311's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/12/2026 in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The MDS indicated R311 was receiving more than 50% of his nutrition through an IV line. Review of R311's Physician's Order Set dated 03/27/2026 in the EMR under the Orders tab revealed an order dated 03/06/26 for the resident to receive TPN Electrolytes Intravenous Concentrate (Parenteral Electrolytes) Use 2050 milliliter (ml) intravenously at bedtime for Nutrition infuse over 12hrs (hours) with 1hr (hour) taper up and 1hr taper down. The order dated 03/06/2026 for each lumen of the resident's double lumen Peripherally Inserted Central Catheter (PICC) line to be flushed with ten milliliters (ML) of normal saline twice daily before the administration of the resident's TPN and upon discontinuing the resident's TPN. The order set indicated R311 was to receive nothing to eat or drink by mouth.Review of R311's Nutritional Care Plan dated 03/03/2026 in the EMR under the Care Plan tab indicated that the resident was a nutritional and hydration risk related to TPN dependence. Interventions included, TPN per order. Review of R311's Vital Sign Report dated 03/05/2026 through 03/27/2026 in the EMR under the Vital Signs tab revealed R311 was only weighed once during his admission to the facility on [DATE].Review of R311's daily Skilled Evaluation Notes entered daily from 03/06/2026 through 03/25/2026 in the EMR under the Notes tab revealed nothing to indicate the resident's TPN or PICC line. All of the notes incorrectly indicated R311 was receiving all of his nutrition by mouth. R311 was observed receiving his medications and TPN related care by Registered Nurse (RN7) on 03/25/2026 at 9:37 AM. RN7 stated she was an agency nurse. RN7 began R311's care by using a 10 ml syringe of normal saline to flush only one line (the line not in use for administering the resident's TPN) with five ml of the saline solution. RN7 did not discontinue R311's TPN while providing care even though the alarm on the pump infusing the TPN repeatedly sounded and the bag of TPN, the resident was receiving was empty. During an interview on 03/25/2026 at 9:49 AM, RN7 stated that she did not disconnect R311's TPN while providing care because the resident's TPN was ordered to infuse continuously (24 hours per day/seven days per week). RN7 stated she did not flush both lumens of the resident's PICC line because one of the lumens was being used to infuse TPN and so did not need to be flushed. RN7 stated that her practice was to flush the other unused lumen with five ml of normal saline at the beginning of her shift and then with another five ml of saline sometime later in her shift (for a total of a 10 ml flush during her shift). RN7 stated she never stopped a resident's TPN to flush the lumens of (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's PICC line. During an interview on 03/25/2026 at 10:05 AM, RN/Unit Manager (RN1) confirmed R311's physicians orders indicated the resident was to have his TPN infused over 12 hours beginning at approximately 9:00 PM each night. She confirmed the resident's TPN did not run continuously (24 hours per day/seven days per week) and confirmed RN7 should have discontinued the resident's TPN while providing care and then flushed each of the lumens on the resident's PICC line with 10 ml of normal saline according to the resident's physician's orders. RN1 stated she did not know if RN7 was competent to provide TPN related care as that was not something she was responsible for verifying.2. Review of R76's admission Record dated 03/27/2026 and located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE] with diagnoses of noninfective gastroenteritis and colitis, Crohn's disease and short bowel syndrome. The record indicated the resident was discharged from the facility on 03/11/2026. Review of R76's admission MDS with an ARD of 03/04/2026 in the EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The record indicated R76 was receiving more than 50% of his nutrition through an IV line. Review of R76's Physician's Order Set dated 03/27/2026 in the EMR under the Orders tab revealed an order dated 02/25/2026, for the resident to receive TPN Electrolytes Intravenous Concentrate use 2000 ml intravenously at bedtime for Nutrition infuse over 14hrs with 1hr taper up and 1hr taper down. The order set did not indicate orders for the resident's double lumen IV PICC line, orders for changing the resident's PICC line dressing or orders for the maintenance or flushing of the PICC line utilized to administer the resident's TPN. Review of R76's Medication Administration Record (MAR) dated 02/25/2026 through 03/27/2026 in the EMR under the Orders tab revealed the resident did not receive his ordered TPN on 03/10/2026 and revealed the resident's PICC line dressing was not changed until one day prior to his discharge from the facility on 03/10/2026.Review of R76's Orders/Administration Notes dated 03/10/2026 in the EMR under the Notes tab revealed R76's TPN was not administered on that dates due to the TPN not being available from pharmacy. Review of R76's Nutritional Care Plan dated 03/03/2026 in the EMR under the Care Plan tab indicate the resident was at nutritional and hydration risk related to TPN dependence in the presence of Crohn's disease. Interventions included TPN per order. Review of R76's Vital Sign Report, dated 02/25/2026 through 03/11/2026 in the EMR under the Vital Signs tab revealed R76 was never weighed during his admission to the facility.Review of R76's daily Skilled Evaluation Notes dated 02/28/2026, 03/06/2025 and 03/09/2026 in the EMR under the Notes tab revealed nothing to indicate the resident's TPN or PICC line. Daily skilled evaluation notes were absent from the resident's record for all other days of the resident's admission to the facility. During an interview with the Administrator and Director of Nursing (DON) on 03/25/2026 at 2:15 PM, the DON stated her expectation was that all orders related to the care and maintenance of a resident's PICC line and TPN administration were expected to be entered into the resident's record immediately upon admission the facility or initiation of treatment. Nurses caring for resident's receiving TPN and/or with a PICC line in place were expected to accurately document route of nutritional intake, the presence of the PICC line and administration of TPN in their daily progress notes. Nursing staff responsible for providing care to residents receiving TPN were expected to follow physician's orders and provide competent care related to the resident's TPN and IV/PICC line. The DON further stated monitoring of resident's weights while receiving TPN was expected to be completed upon admission, and then weekly for four weeks after admission to ensure adequate caloric intake. Cross reference to F726

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observations, record review, staff interviews, and review of facility policy, the facility failed to ensure 32 out of 33 Agency Nurses and 83 out of 83 in-house staff nurses were competent to provide Total Parenteral Nutrition (TPN) related care and services to residents residing in the facility, including one Resident (R) R311 of two residents in the facility receiving TPN. The facility's failure to ensure nursing staff was competent related to the administration of TPN created the potential residents to experience a decline in physical status. Findings include:Review of the facility's policy titled, Competency Evaluation Policy dated April 2025 indicated, It is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job; and Competency: is a measurable pattern of knowledge, skills, abilities, behaviors and other characteristics that an individual needs to perform work roles or occupational functions successfully; and 1. The knowledge and skills required among staff to meet residents' needs are determined through the facility assessment process. 2. Evaluating competency of staff is accomplished through the facility's training program. 3. Initial competency is evaluated during the orientation process. An employee remains on orientation until all competencies are verified. 4. Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations. 5. A variety of methods may be used to evaluate learning and/or skills competency. Examples include but are not limited to: a. Lecture or demonstration with return demonstration by the employee. b. A pre- and post-test for the learning activity. c. Direct observation of the employee's ability to demonstrate use of tools, devices or equipment. d. Direct observation of the employee's ability to perform specific tasks. e. Review of the employee's documentation. f. Peer review or interviews with other staff, residents, and/or families. g. Review of adverse events or other data. 6. Checklists are used to document training and competency evaluations. 7. Only designated individuals may verify competency: a. Staff Development Coordinator b. Orientation Preceptor c. Department Head/Administrator d. Higher level employee/professional who has demonstrated competency e. Consultant expert f. Physician. 8. Employee competency forms are maintained in the Staff Development Coordinator's office for current training year, then forwarded to the Human Resources Director for placing in the employee's personnel file. Review of R311's Physician's Order Set dated 03/27/2026 in the EMR under the Orders tab revealed an order dated 03/06/2026 for the resident to receive TPN Electrolytes Intravenous Concentrate (Parenteral Electrolytes) Use 2050 milliliter (ml) intravenously at bedtime for Nutrition infuse over 12hrs (hours) with 1hr (hour) taper up and 1hr taper down. The order dated 03/06/2026 for each lumen of the resident's double lumen Peripherally Inserted Central Catheter (PICC) line to be flushed with ten milliliters (ML) of normal saline twice daily before the administration of the resident's TPN and upon discontinuing the resident's TPN.Review of the facility's Facility assessment dated 2025/2026 revealed the facility admitted residents who were receiving TPN. The assessment indicated nursing staff would be appropriately trained and competent to provide TPN related care. Review of the facility's nurse training and competency documentation revealed none of the facility staff nurses currently working in the facility had ever received training or demonstrated competency related to the care of residents receiving TPN.Review of the facility's nurse training documentation (provided to the facility by the Staffing Agency) revealed a document that showed one agency nurse who worked in the facility in the most recent 30 days signed an attestation to indicate she was competent to provide TPN related care. The facility was not able to provide any documentation to show that any of the other agency nursing staff who had worked in the facility in the most recent 30 days had received training or demonstrated competency related to the care of residents receiving TPN. Observation on 03/25/2026 at 9:37 AM, R311 was observed receiving his medications and TPN related care by Registered Nurse (RN7). RN7 stated she was an agency nurse. RN7 stated she had not received (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	training from the facility or the agency for which she worked, however she stated she had skills with working with TPN. RN7 began R311's care by using a 10 ml syringe of normal saline to flush only one line (the line not in use for administering the resident's TPN) with five ml of the saline solution. RN7 did not discontinue R311's TPN while providing care even though the alarm on the pump infusing the TPN repeatedly sounded and the bag of TPN, the resident was receiving was empty. During an interview with RN/Unit Manager (RN1), the Director of Nursing (DON) and the Administrator on 03/27/2026 at 11:01 AM, all three stated their expectation was all nursing staff working in the facility were expected to be competent to provide TPN related care since the facility routinely admitted residents receiving TPN as identified on the most recent Facility Assessment. Cross-reference to F694