



September 8, 2025

**IMPORTANT NOTICE-PLEASE READ CAREFULLY
SENT VIA INTERNET EMAIL TO:
triciaholloway@arborcompany.com**

Tricia Holloway (Executive Director)
12200 Crabapple Road
Alpharetta, Georgia 30004

**Re: Arbor Terrace Crabapple
Notice of Survey Results (NOSR)**

Dear Ms. Holloway:

On 7/11/2025, staff from the **Department of Community Health (DCH), Healthcare Facility Regulation Division (HFRD), Personal Care Home Program**, completed a survey of the above referenced facility to assess compliance with Rules and Regulations **Chapter 111-8-63. (Assisted Living Communities)**.

1. REPORT OF MOST RECENT SURVEY

Based on the survey findings:

 No violations of the Rules and Regulations of the above referenced Program were cited. Attached is a copy of the Survey Report for your records.

 X **Violations of the Rules and Regulations for the above referenced chapter**, were cited. Any cited violations are subject to supervisory review and may be deleted, corrected, or have additional violations added. Any revisions of the survey report will be sent under separate cover along with an amended survey report. If the cited violations have resulting and/or additional enforcement action, this notification will be sent after the allowed period for disagreement.

2. STATEMENT OF DISAGREEMENT

- A.** If the administrator/provider does not desire to dispute the deficiencies cited in the inspection report, pursuant to **Rules and Regulations for the above referenced chapter**, a Plan of Correction (POC) must be developed and submitted to the Department, within 10 days of receipt of this letter.



B. If the administrator or provider disagrees with any of the deficiencies noted in the Survey Report and wishes to contest the findings, they may request an Informal Dispute Resolution Review (IDRR) by submitting a written Statement of Disagreement (SOD) to the program for review. **The (SOD) must be submitted within ten (10) days of receipt of this letter ALONG WITH the Plan of Correction (see paragraph 3).** The SOD must include documentation, witness statements or other evidence showing the deficiency was cited in error. Failure to submit appropriate evidence will not alter the survey results. The program leadership will review your IDRR and Statement of Disagreement to make a determination. **Note - Additional violations may be cited after reviewing of the Statement of Disagreement.**

- (i) If the Department partially or fully agrees with the Statement of Disagreement, the violations noted in the inspection report may be deleted or corrected, potentially leading to a reduction or elimination of pending enforcement actions. A revised survey report will be sent under separate cover reflecting the amended information.
- (ii) If the Department disagrees with your Statement of Disagreement, the Adverse Action letter, associated with the cited violations will be sent to you under separate cover. A revised 2567 Survey Report will be sent under separate cover.

3. PLAN OF CORRECTION (POC)*

Pursuant to the General Licensing and Enforcement Rules and Regulations Chapter 111-8-25-.06(6), within ten (10) days of receipt of the inspection report you **MUST** submit a written plan for correcting any rule violations identified. This rule also provides that you may also submit, a Statement of Disagreement along with the POC.

The POC shall:

- Identify the methods and procedures to be used in the correction of the deficiencies;
- Identify the dates corrections have or will be completed; and
- Specify how the facility will monitor the corrections to achieve and maintain compliance.

The date by which corrections must be completed shall be **no later than thirty (30) days** from the {9/8/25}. Your POC will be kept on file. It is the facility's responsibility to monitor the effectiveness of the POC. The POC will be reviewed in addition the program may conduct a follow-up inspection, as necessary.

Please submit the Plan of Correction to the program through the portal link provided in a separate email. The portal may also be accessed at <https://gahles.dch.georgia.gov>

4. ENFORCEMENT ACTION



Pursuant to the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, R&R Chapter 111-8-25, the Department may impose a sanction for the violation of any rule. Notice to the governing body regarding the imposition of a sanction will be sent under separate cover after the period to submit a Statement of Disagreement has expired or after the written notification of the program's decision of the Statement of Disagreement has been communicated to the administrator/provider. Failure to correct violations or failure to maintain compliance once corrections are made may result in further sanctions, including revocation of your permit.

NOTE: For Long Term Care Facilities – J Level or higher severity level violations, which causes death or serious physical harm carry a **mandatory minimum fine of \$5,000**. Any mandatory fine imposed by the Department may not be reduced on the basis of financial hardship.
See: R & R 111-8-25-.05(1) (e) (5) (i).

5. POSTING OF THE INSPECTION REPORT

DCH-HFRD Rules and Regulations require that the most recent inspection report and POC must be displayed in the home in a location that is routinely used to communicate information to the residents. If the community maintains a website, it shall post a web link on the main page, to provide access to copies of the inspection reports and POC for the previous 18 month. The attached survey report will be on file and will be available online at <https://forms.dch.georgia.gov/HFRD/>.

If we may be of assistance, please do not hesitate to call or email.

Sincerely,

Minea Andrews

Minea Andrews, Regional Director
Personal Care Home Program
pchprogram.hfrd@dch.ga.gov
Healthcare Facility Regulation Division

Enclosures

cc: Facility File

¹ The Plan of Correction (POC) may also be mailed to the undersigned at 2 Martin Luther King Jr. Drive SE, East Tower, Atlanta, GA 30334.

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALC000542	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING:	(X3) DATE SURVEY COMPLETED: 8/13/2025
NAME OF PROVIDER OR SUPPLIER Arbor Terrace at Crabapple		STREET ADDRESS, CITY, STATE, ZIP CODE 12200 CRABAPPLE ROAD ALPHARETTA GA 30004	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
ASR4 0000	0000 - Initial Comments. The purpose of this visit was to investigate intake #GA50003404. An onsite visit was made on 7/11/25. The investigation was started on 7/11/25, and was completed on 8/11/25.		

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111-8-63-.07(1) ASR4 0700 SS=D	111-8-63-.07(1) 0700 - Owner Governance. The assisted living community must have a functioning governing body which is responsible for providing the oversight necessary to ensure that the community operates in compliance with these rules, the Rules for General Licensing and Enforcement, Chapter 111-8-25, the Rules for Proxy Caregivers, Chapter 111-8-100, as applicable and other applicable state laws and regulations. This RULE is not met as evidenced by: > > > Based on observations, record reviews, and interviews, the facility failed to ensure the governing body provided oversight necessary to ensure the community operates in compliance with the state rules and regulations for 1 or 4 sampled residents (Resident #1) Findings include: A review of a facility incident report (IR) showed on 5/5/25, Resident #1 was found lying on the floor, covered in blood in Resident #2's apartment. IR showed Resident #1 was actively bleeding throughout the scalp with blood throughout his/her hair and face. A review of the facility incident report dated 4/5/25 showed Resident #2 had a previous aggressive behavior when he/she slapped another resident without being provoked. A review of the facility files showed no documentation the facility took any precautions to prevent further incidents. During an interview on 7/11/25 at 10:45 a.m., Staff A stated that Resident #2 had a prior incident on 4/5/25 with another resident where he/she slapped another resident without being provoked. Staff A provided no explanation as to what precautions were put in place to prevent the incident from reoccurring.		
	111-8-63-.25(1)(a) 2501 - Supporting Residents' Rights. The assisted living community must provide to each resident care and services which are adequate, appropriate, and in compliance with state law and regulations. This RULE is not met as evidenced by: > > > Based on observations, record reviews, and interviews, the facility failed to provide each resident care and services which are adequate, appropriate, and in compliance with		

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111-8-63-.25(1)(a) ASR4 2501 SS=D	state law and regulations for 1 or 4 sampled residents (Resident #1) Findings include: A review of a facility incident report (IR) showed on 5/5/25, Resident #1 was found lying on the floor, covered in blood in Resident #2's apartment. IR showed Resident #1 was actively bleeding throughout the scalp with blood throughout his/her hair and face. A review of the witness statement dated 5/5/25 written by Staff D showed he/she reported seeing Resident #2 holding a wheelchair footrest. Statement showed Staff D reported seeing Resident #2's hands were covered in blood and found Resident #1 on the bathroom floor. A review of the facility witness statement dated 5/5/25 written by Staff C, showed that Resident #1 entered Resident #2 apartments when Resident #2 wheeled him/herself out of his/her apartment with bloody clothing, Staff C stated that he/she and Staff D saw Resident #2 had a footrest from his/her wheelchair in his/her hands covered in blood. Resident # 1 was found on the bathroom floor. Statement showed Staff C stated a few weeks prior to the incident both residents were found on the floor. A review of the facility incident report dated 4/5/25 showed Resident #2 had a previous aggressive behavior when he/she slapped another resident without being provoked. A review of the facility files showed no documentation the facility took any precautions to prevent further incidents. During an interview on 7/11/25 at 10:45 a.m., Staff A stated the incident with Resident #1 and Resident #2 was horrible. Staff A stated that the only thing they could think of is that Resident #2 found Resident #1 in he/she bathroom and got upset. Staff A stated that Resident #2 had a prior incident on 4/5/25 with another resident where he/she slapped another resident without being provoked. A review of Resident #2 file showed that he/she was admitted on 11/29/24, with a diagnosis of OCD Anxiety and Dementia.		

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