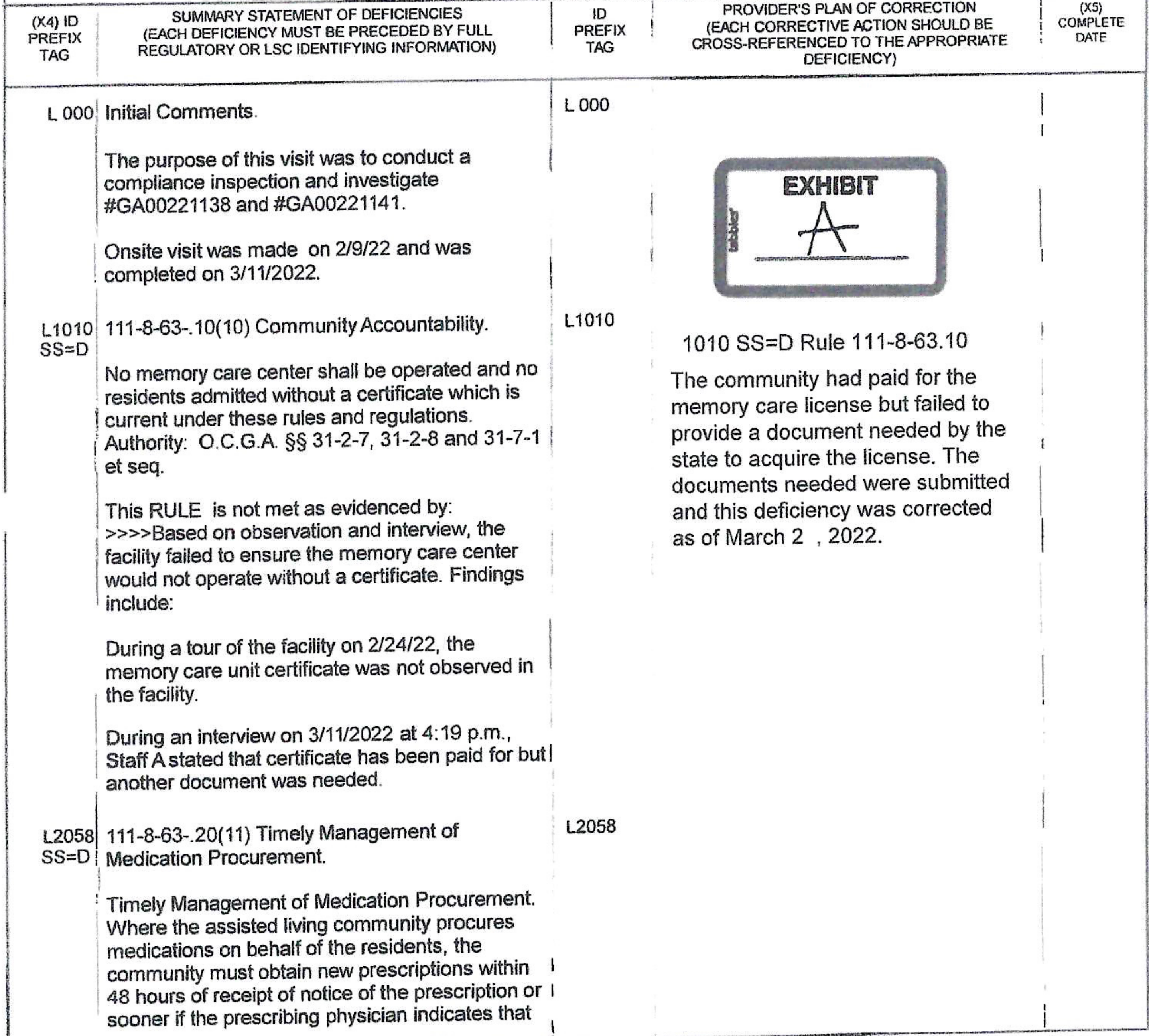
State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000038	A. BUILDING: ______ B. WING ______	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE OF ATHENS	170 MARILYN FARMER WAY ATHENS, GA 30606



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L 000	Initial Comments. The purpose of this visit was to conduct a compliance inspection and investigate #GA00221138 and #GA00221141. Onsite visit was made on 2/9/22 and was completed on 3/11/2022.	L 000	EXHIBIT A	
L1010 SS=D	111-8-63-.10(10) Community Accountability. No memory care center shall be operated and no residents admitted without a certificate which is current under these rules and regulations. Authority: O.C.G.A. §§ 31-2-7, 31-2-8 and 31-7-1 et seq. This RULE is not met as evidenced by: >>>>Based on observation and interview, the facility failed to ensure the memory care center would not operate without a certificate. Findings include: During a tour of the facility on 2/24/22, the memory care unit certificate was not observed in the facility. During an interview on 3/11/2022 at 4:19 p.m., Staff A stated that certificate has been paid for but another document was needed.	L1010	1010 SS=D Rule 111-8-63.10 The community had paid for the memory care license but failed to provide a document needed by the state to acquire the license. The documents needed were submitted and this deficiency was corrected as of March 2 , 2022.	
L2058 SS=D	111-8-63-.20(11) Timely Management of Medication Procurement. Timely Management of Medication Procurement. Where the assisted living community procures medications on behalf of the residents, the community must obtain new prescriptions within 48 hours of receipt of notice of the prescription or sooner if the prescribing physician indicates that	L2058		

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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L2058	Continued From page 1 a medication change must be made immediately. If the pharmacy does not have the medication needed for the immediate change, available and has not obtained further directions from the physician, the community must notify the physician of the unavailability of the prescription and request direction. Refills of prescribed medications must be obtained timely so that there is no interruption in the routine dosing. Where the assisted living community is provided with a new medication for the resident, the MAR must be modified to reflect the addition of the new medication within 48 hours or sooner if the prescribing physician indicates that the medication change must be made immediately. This RULE is not met as evidenced by: >>>> Based on observation, record review, and staff interview, the facility failed to ensure that refills of prescribed medications were obtained timely so that there was no interruption in the routine dosing for 2 of 5 sampled residents (Resident #2 and Resident #3). Findings include: A review of the medication administration record for Resident #2 and Resident #1 showed the following medications were prescribed and were not available in the medication cart: Resident #2: 1. Antidiar-Loperamide - (stool softener) 2. Biscacodyl - (constipation) Resident #3: 1. ProAir (Albuterol sulfate- inhaler- breathing) During an interview on 2/25/2022 at 12:29 p.m.,	L2058	L2058 SS=D Rule111-8-63.20 1) Med Tech in-service on timely procurement of medications to be completed by May 20th, 2022. 2) Weekly Med Cart Audits for 8 weeks by nurse leadership to ensure all medications on MAR are on cart. 3) Daily MAR audit to see if any medications are not available. 4) Leadership to re-educate Med Tech's on procedure for Cart Audits. 5) Med Tech's will continue to audit carts on Sunday nights which includes reordering medications. 6) Nurse leadership will meet weekly with ED for 6 weeks to review audits. Then, Nurse leadership will meet with ED bi-weekly for 2 months, then nurse leadership will meet monthly with ED for the remainder of the calendar year to review audits.	

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L2058	Continued From page 2 Staff F stated the medications for Resident #2 and Resident #3 were not in the medication cart. During an interview on 2/25/2022 at 12:55 p.m., Staff A was aware of the above findings..	L2058		
L2501 SS=J	111-8-63-.25(1)(a) 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 record review, and staff interview, the facility failed to provide to each resident care and services which are adequate, appropriate, and in compliance with state law and regulations for 1 of 5 sampled residents (Resident #1). Findings include: A review of an incident report submitted to the Department on 1/26/22 showed on 1/18/22, Resident #1 fell to the ground while a staff member transported the resident in his/her wheelchair using the lift from the community van for a dental appointment.. Apparently, the lift collapsed during transfer, and the resident fell to the ground including the caregiver. Resident #1 was transferred to the emergency room for evaluation and treatment. Resident #1 sustained injuries to his/her legs and scalp. A review of a facility reported incident showed on 1/18/2022, around 3:00 p.m., Staff D transported Resident #1 for a dental appointment. Staff D engaged the van emergency brakes and unfolded the lift. Staff D rolled the resident onto the ramp	L2501	L2501 SS=J Rule 111-8-63.25 1) Van taken out of use by community and community is using 3rd party transportation for resident's needing wheelchair transportation. Completed on May 25, 2) Vehicle Maintenance Book Created. Completed prior to receiving statement of deficiencies. 3) Vehicle Maintenance Book reviewed Weekly by Executive Director and Maintenance Director.	

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L2501	Continued From page 3	L2501		

and locked the wheelchair. As Staff D was stepping off the lift to get back on the bus to lower the lift, the lift fell down onto the ground with Resident #1 and Staff D. Staff D fell on top of the resident. As a result of the fall, the resident sustained lacerations to his/her right and left lateral calf and to his/her head. 911 was called. Resident #1 was transported to the hospital. The resident received stitches bilaterally to his/her legs and two staples to his/her posterior occiput area. Resident #1 was discharged on 1/18/22 from the hospital and he/she returned to the facility.

During a tour of the van on 2/9/2022, a light on the ramp lift was not working, but the lift was working.

A review of the facility 1997 van invoices regarding the lift prior to the incident on 1/18/22 showed that repairs were done on 1/24/19 on the assembling cylinder roll stop and hand pendent, on 1/28/19 on the resealing van lift door(remove and reinstall van lift), and on 9/21/21 assembling gas spring. Additional invoice repair on the lift on 1/26/22 (after the incident), showed leaking hydraulic cylinders, and this part was replaced.

A review of the facility's vehicle maintenance policy showed that the maintenance of vehicle was the responsibility of the maintenance director or community lead driver. The monthly vehicle checklist must be completed by maintenance director once a month.

A review of the facility's vehicle maintenance tracking showed no vehicle check for the 1997 van, prior to using the van on 1/18/22.

A review of the hospital discharge summary

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L2501	Continued From page 4	L2501		

report dated 1/18/2022 for Resident #1 showed on 1/18/2022, the resident went to the hospital due to a fall and generalized weakness. The resident was diagnosed with altered mental status, concussion with loss of consciousness, initial encounter, laceration of left lower extremity, initial encounter, laceration of scalp, initial encounter, muscle strain, and fall from height greater than 3 feet. On 1/19/2022, the resident visited the hospital for back pain. Resident #1 was admitted to the hospital on 1/20/2022 and passed away on 1/23/2022 at the hospital.

A review of the death certificate, dated 2/22/2022, showed that acute hypoxic respiratory failure, wound dehiscence, and acute chronic pain directly caused the death of Resident #1.

During an interview on 2/9/2022 at 1:30 p.m., AA stated on 1/18/2022, Resident #1 fell at a dentist office parking lot while Staff D was getting the resident out of the facility van. AA stated that Staff D fell on Resident #1, and the resident went to the hospital. AA stated that Resident #1 was examined and received 27 stitches to the legs and two in the scalp.

During an interview on 2/24/22, Staff D declined and refused to talk about the incident that occurred on 1/18/22.

During an interview on 3/11/2022 at 4:19 p.m., Staff A stated prior to 1/18/22, the last date the van was used was 8/17/2021 for two doctors appointments at 11:00 a.m. and 3:20 p.m.

A review of the file for Resident #1, admitted on 5/25/2021, showed diagnoses of diverticulitis, duodenal ulcers, arthritis, toe melanoma, cataracts, congestive heart failure, obesity, atrial

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L2501	Continued From page 5 fibrillation, gout, rhinitis, dry eye syndrome, trigger finger right and left, hypertension, MFpEF (heart failure with preserved ejection fraction), PAD (peripheral arterial disease) , venous insufficiency, diabetes mellitus, neuropathy, and chronic kidney disease stage 3. Resident #1 needed one person assist with transfers. Resident #1 passed away on 1/23/2022 at the hospital..	L2501		