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	05/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{L 0000}	The purpose of this survey was to investigate #GA00223269. The onsite visit was on 5/5/2022 and investigation was completed on 5/27/2022.
{L 1700} SS= D	>>>>Based on record review and interview the facility failed to provide protective care and watchful oversight the residents it retains for 1 of 3 residents (Resident #1). Finding include: A review of the facility incident reports showed on 3/4/2022 that Resident #1 had an unwitnessed fall in his/her room. While Resident #1 was attempting to go to the restroom, he/she slipped and fell. On 3/5/2022, a relative of Resident #1 visited him/her and stated that the resident was in pain. The relative made staff aware of how the right's skin appeared. The relative stated that he/she wanted the resident to go to the hospital. Resident #1 was transported to the hospital and was with a diagnosis of right posterior rib pain with right 9th rib fracture status post fall. A review of the facility note entered on 3/4/2022 at 4:47 p.m. for Resident #1 showed that the resident had a fall while attempted to go to the bathroom. Staff E heard a loud noise and went into the room of the resident. The resident was found lying on the floor. Resident #1 was assessed and then assisted into the bathroom. Another facility note entered on 3/4/2022 at 6:31 p.m., (initial fall) showed that Staff E alerted Staff B that Resident #1 had fallen on the floor. The resident was assessed by Staff B with performing range of motion. The resident was asked if he/she was in pain, and the resident stated that his/her side was hurting. Resident # 1 was given ibuprofen scheduled as needed. Vitals were taken. The relative, physician, and facility nurse were notified. On 3/5/2022 at 4:18 a.m., follow-up to the fall (10 hours and 13 minutes later) Resident #1 was checked on and had no complaints. The resident was sent to the hospital at 11:00 a.m. due to the right side rib area was swollen as a result of the fall. A review of the file for Resident #1, admitted 7/15/2021, showed a diagnosis of Parkinson disease.

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	A review of the hospital discharge summary on 3/5/2022, showed a diagnosis of subtle abnormality to the right ninth rub which represented a displaced fracture based on his/her injury and physical exam findings. During an interview on 5/5/2022 at 8:45 a.m., AA stated on 3/4/2022, that Resident #1 was found on the floor. During an interview on 5/5/2022 at 11:25 a.m., Resident #1 stated that he/she tripped over his/her exercise bin. Resident #1 stated that he/she was hurting. The resident stated that the pain increased overnight and the next day, he/she was given medications to reduce the pain. Resident #1 stated that he/she could not get staff to do anything about the pain. Resident #1 stated that the pain keep getting worst. The resident stated he/she told staff that he/she needed some medication for pain. Resident #1 stated around 11:00 p.m., that staff told him/her that staff had to get permission from management for him/her to go to the emergency room because direct staff cannot make the decision. Resident #1 stated that staff called his/her relative and asked the relative to get him/her. Resident #1 stated it took more than three hours for the relative to get to the facility. During an interview on 5/27/2022 at 3:15 p.m., Staff A was aware of the finding.