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 _____	12/19/2022

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	Initial Comments. >>>>The purpose of this visit was to investigate intake GA00228662 and GA00228760. An onsite visit was made on 11/2/22 and the investigation was completed on 12/19/22.	L 000		
L2510 SS=D	111-8-63-.25(1)(g) Supporting Residents' Rights. Each resident must be treated with dignity, kindness, consideration and respect and be given privacy in the provision of assisted living care. Each resident must be accorded privacy and freedom to use the bathroom(s) at all hours. This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure each resident was treated with dignity, kindness, consideration, and respect for 1 of 2 sampled residents (Resident #2). Findings include: A review of the file for Resident #2, admitted 2/12/18, showed diagnoses of dementia, hyperlipidemia, GERD, Parkinson's, peripheral neuropathy, vestibular disorder, orthostatic hypotension, diabetes, CVA, and arthritis. A review of the facility incident report showed that on 10/7/22 at approximately 1:00 p.m., a staff member fed Resident #2 and spoke aggressively to him/her. A review of a staff statement dated 10/7/22, showed that Staff F said that he/she heard Staff D yell at the residents in a strong tone. He/she looked over and saw Staff D push Resident #2 in a wheelchair with a lot of force over to the table. Staff D proceeded to feed Resident #2 with a	L2510	**L2510 Supporting Residents' Rights** **Accused staff member was suspended and subsequently terminated after investigation.** **This community did a residents rights in-service for all staff, which included different types of abuse, mandated reporting, how to recognize abuse and who to report it to as well the residents right to choose.** **Resident Care Director had individual and group education surrounding resident rights and abuse training.** **This community reviewed our training plan to ensure all new hires are receiving resident rights and abuse training in a way that is understandable and practical.** **This community committed to ensuring resident rights and abuse training happens every 6 months in addition to on-boarding and annually assigned Relias training.** **This community interviewed all alert and oriented residents to inquire if resident had witnessed abuse or mistreatment.** **This community interviewed staff from 3 different shifts to inquire if staff had witnessed abuse or mistreatment of any residents.**	

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L2510	Continued From page 1	L2510		

spoon, forcing the spoon in his/her mouth, making his/her head pop back. Staff F immediately went to Staff D and said, you don't have to feed him/her like that. Resident #2 had already eaten 75% of his/her meal, so Staff F told Staff D there was no need to force him/her to eat. Then Resident #2 began eating on his/her own, like he/she was scared.

A review of the statement for Staff D, dated 10/10/22, stated that he/she was feeding another resident when Resident #2 tried to leave the table. Staff D stated that he/she went over to Resident #2 and pushed him/her back to the table to try and help him/her eat. After pushing him/her to the table Staff D stated that he/she tried to put food in Resident #2's mouth as he/she will sometimes take it. Staff F stated that Resident #2 swallowed the food. Then Staff D came over and said not to feed Resident #2 because he/she fed him/herself. Staff F brought him/her pudding and gave it to Resident #2 while Staff D was there. Staff D stated that Staff F said, you need to be gentle with him/her.

A review of the file for Staff D showed that he/she was terminated on 10/14/22 for misconduct.

During an interview on 12/15/22 at 2:16 p.m., Staff F stated that on the date of the incident, he/she saw Resident #2 trying to leave the table and Staff D got up and shoved him/her towards the dining room table in his/her wheelchair and Resident #2 caught the table out in front of him/her with his/her friends. Staff F stated that Staff D was feeding another resident at the time and was telling him/her, you have to eat or you're going to die, prior to getting up and pushing Resident #2 back to the table. Staff F stated that Staff D then grabbed a spoon and began putting

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L2510	Continued From page 2 food in Resident #2's mouth, forcing his/her head to push back. Staff F stated that you could tell that Resident #2 was scared and began feeding him/herself after that. Staff F stated that no one else witnessed the incident. During an interview on 12/19/22 at 2:17 p.m., Staff A stated that he/she watched the video footage and saw Resident #2 hold his/her hand up to tell Staff D that he/she was finished eating but Staff D fed Resident #2 anyway causing his/her head to move back.	L2510		