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
	ALC000198	A. BUILDING: _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT HAMILTON MILL	3581 BRASELTON HIGHWAY DACULA, GA 30019

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L 000	Initial Comments. >>>>The purpose of this visit was to conduct a compliance inspection and investigate intake #GA00212407. An onsite visit was made on 3/30/21 and the inspection was completed on 4/22/21.	L 000		
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 ensure each resident received care and services which were adequate, appropriate, and in compliance with state law and regulations for 1 of 3 sampled residents (Resident #1). Findings include: A review of the incident report submitted to the Department dated 2/23/21, showed the facility notified a family member (FM) that Resident #1 had fallen on 12/8/2020. Resident #1 was transferred to the emergency room (ER) for evaluation and treatment on 12/9/2020 because the resident complained of hip pain. ER doctor informed FM that the resident had the "worse possible scenario of a broken hip" and needed hip replacement surgery. ER doctor also told FM that Resident #1 had to wait for 2-3 days for the surgery because of the blood thinner medication he/she was taking. Resident #1 had severe pain with movement and had bruises on his/her arms and his/her thigh. Sixteen (16) hours had passed from the time Resident #1 had fallen	L2501		

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L2501	Continued From page 1 when he/she was transported to the ER. Resident #1 lost about 3 pints of blood and needed a blood transfusion prior to surgery. On 12/12/2020, Resident #1 had hip replacement surgery. On 12/13/2020, Resident #1 health declined, and he/she expired on 12/14/2020. A review of the facility incident report dated 12/10/2020 showed Resident #1 was found lying on the floor in the hallway. Resident #1 was unable to provide details of the fall due to his/her dementia. The third shift staff reported that Resident #1 slept throughout the night. On 12/9/2020, during the 6:30 a.m. rounds while caregiver was checking Resident #1, Resident #1 was observed holding his /her right leg and biting his/her lip. Resident #1 was given pain medication and transported to the hospital. A review of Emergency Medical Services (EMS) report showed on 12/9/2020 responded to a call from the facility that involved a resident fall. EMS was informed by care staff that Resident #1 had fall and started complaining of pain 30 minutes prior to EMS arrival. Report showed Resident #1 had a bruise and swelling to his/her upper right leg and bruise was tender to touch. A review of the hospital medical records showed on 12/9/2020 at 8:03 a.m. Resident #1 arrived at the ER regarding a ground level fall and complained of severe/constant right hip pain. X-ray report showed Resident #1 had a right impacted femoral neck fracture. Resident #1 was diagnosed with closed displaced basicervical fracture of right femur, closed fracture of neck of right femur, dementia, and atrial fibrillation (irregular heartbeat), anemia due to blood loss, hypertension, hyperlipidemia, and acute kidney injury.	L2501		

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L2501	Continued From page 2 A review of the facility's charting notes showed the following: 1. On 12/8/2020 at 3:30 p.m., Resident #1 was found lying on the floor. Resident #1 was unable articulate what happened. No injury noted and Resident #1 denied pain. Resident #1 vital signs were blood pressure (B/P) 87/54 and pulse (P) 63. Resident #1's responsible party and doctor were notified of the fall. There was no documentation to show that the blood pressure of 87/54 was reported to the doctor and no documentation to show the facility's nurse was notified. 2. On 12/8/2020 at 5:30 p.m. Resident #1's B/P was 95/80 and P- 63. There was no documentation to show that the B/P of 95/80 was reported to the doctor. 3. On 12/9/2020 at 4:34 a.m., showed Fall follow-up, Staff E noted Resident #1's B/P was to low during second shift which was 87/54. at 2:00 a.m. and B/P was 88/45, pulse 72. Staff E noted no pain or discomfort. Staff E noted he/she would have next shift to continue to monitor blood pressure. There was no documentation to show that the B/P of 88/45 was reported to the doctor. 4. On 12/9/2020 at 6:58 a.m., Staff E noted during rounds Resident #1 was shaking. Resident #1 B/P was 117/48. Staff E noted Resident #1 was given Acetaminophen 325 mg tablet was given for pain. Staff E noted he/she would continue to monitor Resident #1. There was no documentation to show where Resident #1's pain was located. 5.. On 12/9/2020 at 8:20 a.m., showed Fall	L2501		

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L2501	Continued From page 3 follow-up, Resident #1 was transported to the ER for complaint of pain. There was no documentation to show where Resident #1's pain was located. A review of the December 2020 Medication Administration Record (MAR) for Resident #1 showed on 12/9/20 at 7:07 a.m., Resident #1 was given Acetaminophen 325 mg prescribed every 8 hours as needed for pain. There was no documentation to show where Resident #1's pain was located. MAR showed Resident #1 was prescribed the following medications: 1. Eliquis 2.5 mg twice a day (blood thinner) 2. Metoprolol ER 25 mg at bedtime (hypertension) A review of the facility's policy for nighttime wellness checks showed the facility assumed responsibility for the health, safety, and wellbeing of the residents. Policy further showed care staff would check on residents at "regular intervals" during sleeping hours. A review of the facility's falls protocol dated 4/15/21 showed after every fall an incident report was completed and the resident was placed on 72 hours follow-up charting. A further review of the file for Resident #1 showed no documentation of a 72 hours follow-up charting. A review of the facility's staff checking report for Resident #1 showed the following: 1. On 12/8/2020, Resident #1 was check at 7:43 p.m., at 7:45 p.m. at 7:47 p.m., at 7:50 p.m., at 9:01 p.m., and at 11:03 p.m. No documentation to	L2501		

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L2501	Continued From page 4 show that Resident #1 was checked on at 5:30 p.m. 2. On 12/9/2020, Resident #1 was check at 1:20 a.m., at 5:00 a.m., and at 5:21 a.m. A review of the state death certificate dated, 12/22/20 for Resident #1 dated 12/14/20 showed dementia as immediate cause, and recent fracture of the right femur was the significant condition contributing to death. During an interview AA stated Resident #1 had moderately severe dementia and was in the facility's memory care unit. AA stated on 12/8/2020 at 3:30 p.m. he/she received a call from the facility staff, but did not give his/her name, to report that Resident #1 had fallen and that the Resident #1 was alright. AA stated staff did not ask if he/she wanted to send Resident #1 out to hospital for evaluation. AA stated Resident #1 was found on the floor and no one witnessed his/her fall. AA stated on 12/9/2020 at around 7:30 A.M. to 7:45 a.m. he/she received a phone call from Staff D and informed him/her that Resident #1 complained of leg pain when staff attempted to get him/her out of bed and dressed. AA stated Staff D called back and told him/her that Resident #1 was transported to the hospital for evaluation and treatment because he/she complained of hip pain. AA stated the emergency room (ER) doctor checked on Resident #1 and stated that Resident #1 had the worst possible scenario of a broken hip. AA stated that the hip bone of Resident #1 was totally shattered and he/she needed a right hip replacement. AA stated the surgery of Resident #1 was postponed 2 to 3 days due to the blood thinner medication he/she was taking. AA also stated the ER doctor asked why Resident #1 was not transported to the ER	L2501		

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L2501	Continued From page 5 immediately after his/her fall. AA stated 16 hours had passed from the time Resident #1 was found on the floor at the facility until he/she was transported to the ER. AA stated hospital doctor reported that Resident #1 lost a lot of blood due to the blood thinner medication. AA stated Resident #1 lost about 3 pints of blood from internal bleeding around his/her hip fracture. AA stated Resident #1 received 2 pints of blood on 12/11/2020. AA stated on 12/12/ 2020, Resident #1 had hip replacement surgery. AA stated on 12/13/20 Resident #1 took turn for the worse, his/her kidneys stopped functioning, and passed away on 12/14/20. During an interview on 3/30/21 at 1:47 p.m., Staff C stated on 12/8/2020 around 3:30 p.m. he/she found Resident #1 lying on the floor in the hallway. Staff C stated he/she assisted Resident #1 from the floor and walked him/her back to his/her room. Staff C stated he/she moved Resident #1's legs up and down and Resident #1 showed no sign of pain and he/she did not complain of pain. Staff C stated he/she notified Resident #1's family of the fall. Staff C stated Resident #1 was not evaluated by a nurse or doctor. and he/she did not witness the fall of Resident #1. Staff C stated he/she checked on Resident #1 several times during his/her shift and he/she showed no signs of pain. Staff C stated on 12/8/2020 Resident #1 did not have any visible bruises. During an interview on 3/31/21 at 1:55 p.m., Staff D stated on 12/8/2020 during the 3:00 p.m. to 11:00 p.m. shift, Resident #1 had a fall. Staff D stated on the morning of 12/9/2020 Resident #1 was sent out just before 7:00 a.m. by Staff E. Staff D stated Staff E reported that Resident #1 was grimacing when he/she checked him/her and	L2501		

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L2501	Continued From page 6 Staff E decided to send the resident out to the hospital. Staff D stated Resident #1 was not assessed by a nurse or doctor after the fall. Staff D stated staff observed Resident #1 during their shifts after the fall. Staff D stated Staff E notified Resident #1's family when he/she was sent to the hospital. Staff D stated he/she spoke with Resident #1's family member on 12/9/2020 about the fall and was notified that Resident #1 was scheduled for surgery for a fracture of neck of the right femur. During an interview on 4/13/21 at 8:30 a.m., Staff E stated that Resident #1 had a fall on the evening of 12/8/2020. Staff E stated he/she worked on 12/8/2020 from 11:00 p.m. to 7:00 a.m. and he/she was informed by the 3:00 p.m. to 11:00 p.m. shift that Resident #1 had a fallen. Staff E stated he/she checked on Resident #1 several times during his/her shift and Resident #1 was asleep. Staff E stated Resident #1 was independent with toileting and was able to get out of bed unassisted. Staff E stated on 12/9/2020 during his/her of check of Resident #1 the resident made moaning sounds as he/she entered the room. Staff E stated he/she asked Resident #1 if he/she was in pain and Resident #1 said no. Staff E stated he/she checked Resident #1 by touching his/her legs and Resident #1 yelled out in pain stating "my leg, my leg". Staff E stated Resident #1 was shaking/trembling. Staff E stated Resident #1 was unable to articulate that he/she was in pain due to dementia. Staff E stated he/she notified Staff D, gave Resident #1 a Tylenol, and called 911 to transport to the hospital. During an interview on 4/19/21 at 12:40 pm., Staff D stated residents in memory care received standard checks every 2 hours. Staff D stated	L2501		

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L2501	Continued From page 7 after Resident #1's fall on 12/8/20, the care staff should have checked on the resident more frequently at least every hour. Staff D stated when staff entered residents' rooms to check on the resident staff pressed the check mark on the pull cord system in the resident's room which recorded the staff check. During an interview on 4/20/21 at 2:29 p.m., Staff A stated after Resident #1 had fallen, the medication aide (MA) was called to the unit. Staff A stated the MA asked the resident if he/she had any pain and observed for non-verbal signs of pain. Staff A stated the MA conducted range of motion with Resident #1 and the resident vital signs were checked. Staff A stated it was the facility policy for staff to conduct a range of motion with a resident after a fall and to check the resident's vital signs. During an interview on 4/21/21 at 10:01 a.m., Staff A stated, in the Department's request for Resident #1's 72 hours charting document, the 72 hours log was an internal document with a 3 months retention and was not a part of the resident's or facility's permanent records. During an interview on 4/22/21 at 11:00 am., Staff D stated that the blood pressure of Resident #1 of 87/54 should have triggered the MA to contact the facility nurse. Staff D stated Resident #1 should have been sent out to the hospital for the low blood pressure. A review of the staff work schedules from 12/1/2020 to 12/31/2020 showed on 12/8/2020, Staff C worked from 3:00 p.m. to 11:00 p.m.,and Staff E worked from 11:00 p.m. to 7:00 a.m. A review of the file for Resident #1, admitted on	L2501		

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L2501	Continued From page 8 6/20/18 showed diagnoses of dementia, weakness, and atrial fibrillation. A review of the physician evaluation dated 6/14/18 showed Resident #1 required assistance from staff during the night. A review of the facility's shared responsibility agreement dated 8/10/2020 showed Resident #1 was assessed as a fall risk.	L2501		

Plan of Correction

This plan shall not be deemed an admission by the Community that the cited deficiencies are factually accurate, that the facts and circumstances set forth in the alleged deficiencies constitute non-compliance, or that any resident of the Community suffered harm secondary to the Community's alleged failures to follow any regulatory requirement.

The Community's intent is to follow all applicable rules and regulations as more fully set forth in Ga. Comp. R. & Regs. 111-8-63-01 et seq. and the interpretive guidelines.

L2501- 111-8-63-25(1)(a)- Prior to the Community's notification of the incident involving Resident #1, the Community had policies and procedures in place to ensure that each resident receives care and services which are adequate, appropriate and in compliance with state laws and regulations. Policies and procedures are also in place related to incident reporting internally and to the appropriate state authorities, as well as related to resident checks. All staff are trained on the policies and procedures upon hire in orientation, and as needed. Staff employment files are audited to verify all necessary training has been provided as required by the state regulations.

On its notification of the incident involving Resident #1, the Community took immediate action to investigate and implement revisions to its policies and processes as needed.

The Community has reviewed all policies to confirm compliance with the state regulations. Revisions were made, if needed, and staff were trained and/or reeducated as required. The policies will be reviewed quarterly by the Care Coordination Committee and as needed on an ongoing basis and revisions or updates made as needed. Any identified policy violations will be addressed by Community leadership.

Resident incidents will be reviewed by the Care Coordination Committee quarterly and on an ongoing basis to ensure Community compliance with applicable policies and retraining provided as needed. In-services will be provided at the stated frequency or as needed to address any deficiencies identified.