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
	ALC000613	A. BUILDING: _____ B. WING _____	07/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLANA EAST COBB, THE	1032 JOHNSON FERRY ROAD MARIETTA, GA 30068

(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 conduct an compliance inspection and investigate intake #GA00215461, GA00215321, GA 00214918 and GA00216713. An on-site visit was made to the facility on 6/27/21. The investigation started on 6/25/21 and was completed 7/19/21.	L 000	111-8-63-.25(1)(a) Supporting Residents' Rights. Staff B completed medication administration retraining. Staff B was removed from his/her position. Registered nurse or pharmacist conducts quarterly random medication administration observations quarterly to assure compliance. Clinical skills competency reviews are conducted for each certified medication aide twice annually after hiring. Random clinical skills observations are conducted quarterly. Resident Care Director or designee will be responsible for adherence to the plan.	Completed 04-21-2021
L2501 SS=D	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. Findings include: A review of facility records for Resident #4 showed an admission date of 3/30/21 with a diagnoses of Dementia, CVA and Behavior disturbance. A review of Resident #4 Medication Administration records showed ; Quetiapine Fum 50 mg(Seroquel 25 mg)tablet, take one(1) tablet by mouth twice daily at bedtime. A review of facility's incident report dated 4/21/21 showed documentation that Staff B administered a extra dose of Seroquel 25 mg to Resident #4. Furthermore, the incident report indicated that the facility notified Resident #4 family and physcian of	L2501		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Freda Meyer* | TITLE: Executive Director | (X6) DATE: 8-24-2021

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L2501	Continued From page 1 this incident. The incident report indicated that Resident #4 did not sustain any injury as a result of the medication error. During an interview at 10:30 a.m. Staff A stated that Staff B mistakenly gave Resident #4 a additional dose of Seroquel 25 mg. Staff A stated the facility notifed Resident #4's family as well as his/her physcian. Staff A stated disciplinary action was taken toward Staff B. Staff A stated Staff B was removed from his/her position. Staff A stated Staff B was retrained in medication administration. During an interview via phone at 2:30 a.m. Staff B stated he/she made a mistake with assisting with giving Resident #4 a second dose of Seoquel 25 mg. Staff B stated he/she had never made a mistake like that before.	L2501		