State of GA, Healthcare Facility Regulation Division

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>>>>The purpose of this visit was to conduct an compilance inspection and investigate intake #GA0021641. 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. L2501 111-8-6325(1)(a) Supporting Residents' Rights. SS=D The assisted living community must provide to each resident care and services which are adequate, appropriate, and in compilance 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 compilance with state law and regulations. Findings include: A review of facility records for Resident #4 showed an administration records showed; Quetiapine Fum 50 mg(Seroquel 25 mg) Italied; to the facility in facility's incident report dated 4/21/21 showed documentation that Staff 8 administered a extra dose of Seroquel 25 mg to Resident #4. Furthermore, the incident report indicated that the	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Freda Meyer

Executive Director

TITLE

8-24-2021

State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED ALC000613 B. WING 07/19/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1032 JOHNSON FERRY ROAD SOLANA EAST COBB, THE MARIETTA, GA 30068 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) L2501 Continued From page 1 L2501 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.