| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALC000669 | A. BUILDING<br>B. WING | 06/18/2021 |

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| MANOR LAKE ELLIJAY | 85 HIGHLAND RIDGE ROAD<br>ELLIJAY, GA 30540 |

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| {L 000} | Initial Comments.<br><br>>>>>The purpose of this visit was to conduct a compliance inspection and investigate intake #GA00214059 and #GA00213875.<br><br>An onsite visit was made on 5/12/21 and the survey was completed on 6/18/21. |

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| {L 0941}<br>SS= D | 111-8-63-.09(19)(a) Staffing.<br>Sufficient staff time must be provided by the assisted living community such that each resident:<br>(a) receives services, treatments, medications and diet as prescribed; ...<br><br>This REQUIREMENT is not met as evidenced by:<br>>>>>Based on record review and interview the facility failed to ensure that sufficient staff time was provided such that each resident received services and treatments as prescribed for 3 of 5 sampled residents (Resident #1, Resident #4, and Resident #5). Findings include:<br><br>A review of the resident census showed 7 wheelchair dependent residents, 6 incontinent residents, and 3 residents with catheters.<br><br>A review of the file for Resident #1, admitted 10/24/20, showed diagnoses of late onset Alzheimer's disease and coronary artery disease. Resident #1 was incontinent of bowel and bladder and resided in the memory care unit (MCU).<br><br>A review of an incident report dated 4/20/21 at 12:26 a.m. showed that Resident #1 fell while attempting to get into bed at approximately 12:26 a.m. on 4/20/21. Resident #1 sat on the floor until family called the facility at approximately 5:30 a.m. to let staff know that Resident #1 was on the floor.<br><br>A review of video footage in the room of Resident #1 captured that he/she fell and laid on the floor from approximately 12:49 a.m. to 5:33 a.m., before staff was seen entering his/her room to pick him/her up off the floor.<br><br>A review of the care plan for Resident #4 showed diagnoses of dementia, sleep apnea, chronic embolism and thrombosis of deep veins of lower extremities, vitamin B12 deficiency, iron deficiency anemia, arthritis, anemia, and hypothyroidism. Resident #4 needed assistance at times in positioning the urinary indwelling catheter bag through his/her pants leg, and also need assistance with emptying the urinary bag.<br><br>A review of the care plan for Resident #5 showed diagnoses of atrial fibrillation, benign prostatic hyperplasia, residual right left extremity weakness, ulcerative colitis, dementia, and gastroesophageal reflux disease. Resident #5 was wheelchair dependent and at times had problems pulling up his/her pants after using the restroom and would call for assistance. |

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A review of the call pendant response log showed the following response times on 4/20/21:

Resident #4

12:42 a.m., 28 minutes

3:40 a.m., 49 minutes

6:33 a.m., 50 minutes

Resident #5

6:54 a.m., 45 minutes

A review of Staff B and Staff C's statements regarding 4/20/21 call response times showed that Resident #4 paged multiple times throughout the night. Resident #4 called for assistance with various things from turning the TV off, toileting, transferring, catheter care, and complained of sore throat to the staff.

During an interview on 6/18/21 at 11:48 a.m., Staff D stated that he/she would check on the policy regarding what was considered an appropriate response time in the facility.

An email was received on 6/18/21 at 4:00 p.m. from Staff D showed that there was no written policy for the appropriate response time when a resident activated the call pendant for assistance. However, seven (7) minutes was the time that staff had been advised as the allowable response time.

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| {L 1924}<br>SS= D | 111-8-63-.19(1)(c)2. Staffing and Initial Staff Orientation.<br>[The assisted living community must ensure:] ...<br>2. At least one staff member who is awake and supervising the unit at all times and sufficient numbers of trained staff on duty at all times to meet the needs of the residents. ...<br><br>This REQUIREMENT is not met as evidenced by:<br>>>>>Based on observation, record review, and interview, the facility failed to ensure that staff supervising the unit had sufficient numbers of trained staff on duty at all times to meet the needs of the residents for 2 of 4 sampled staff (Staff B and Staff C). Findings include:<br><br>A review of the file for Staff B and Staff C, both hired 11/19/20, showed that no training in memory care had been completed.<br><br>A review of LE's supplemental narrative report showed that Staff B and Staff C worked in the facility the night of 4/20/21, with Staff C being assigned to cover the MCU.<br><br>During an interview on 6/18/21 at 11:48 a.m., Staff D stated that Staff A said that Staff B and Staff C had not completed any training working in MCU. |

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| {L 2410}<br>SS= D | 111-8-63-.24(2)(j) Residents' Files.<br>Each resident's file must include the following information: ...<br>(j) an inventory of valuable personal items brought to the assisted living community for use by the resident to be updated at anytime after admission if a resident or representative or legal surrogate, if any, submits to the assisted living community a new inventory of the resident's personal items; ... |

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| | This REQUIREMENT is not met as evidenced by:<br>>>>>Based on record review and interview the facility failed to include in each resident's file an inventory of valuable personal items brought to the community for use by the resident to be updated at anytime after admission if a resident or representative, submits to the community a new inventory of the resident's personal items for 3 of 5 residents (Resident #1, Resident #2, and Resident #3). Findings include:<br><br>A review of files for Resident #1, Resident #2, and Resident #3 showed no inventory of personal items available for review.<br><br>During an interview on 6/18/21 at 11:48 a.m., Staff D stated that they did not have personal inventories of resident's belongings, as their corporate office did not require the above rule. |
| {L 2501}<br>SS= G | 111-8-63-.25(1)(a) Supporting Residents' Rights.<br>The assisted living community must provide to each resident care and services which are adequate, appropriate, and in compliance with state law and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>****>>>>Based on record review and interview, the facility failed to ensure each resident received care and services which were adequate, appropriate, for 1 of 5 sampled residents (Resident #1). Findings include:<br><br>A review of an incident report dated 4/20/21 at 12:26 a.m. stated that Resident #1 fell while attempting to go back to bed at approximately 12:26 a.m. on this date. Resident #1 sat on the floor until family called the facility at approximately 5:30 a.m. and told staff that Resident #1 was on the floor. Resident #1 sustained a bruise to the right buttock. |

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| | A review of video camera footage captured in the room of Resident #1 on 4/20/21 around 12:37 a.m. Resident #1 got out of bed to go to the restroom. At 12:49 a.m., Resident #1 fell to the floor while trying to get back to bed. Resident #1 was on the floor until approximately 5:33 a.m., when staff were observed entering the room of Resident #1.<br><br>A review of the facility's care plan for Resident #1, dated 2/7/21, showed that Resident #1 was a fall risk, had two fall episodes in the past 90 days. Resident #1 should be checked on four times each night by staff.<br><br>A review of a written statement from Staff B showed that around 12:30 a.m., on 4/20/21, he/she made rounds with Staff C in MCU because he/she felt more comfortable with another staff with him/her to ensure all residents were well and sleeping in their beds. After about an hour and a half later, a resident in room #162 paged them for assistance for toileting and transferring. This resident almost fell when he/she assisted him/her before. Both staff also found out that the resident's urinary indwelling catheter was leaking and repositioned the clamp to the catheter. The staff also assisted the resident to his/her recliner, and that took them 30 minutes to assist the resident. Staff B indicated Staff C went back to the MCU. Shortly, thereafter, the resident in room #162 called for assistance again, almost every 15 to 30 minutes after attending to him/her. The resident called for water, to be repositoned in the recliner, for the television to be turned off, and complained of sore throat. After that, he/she went to the MCU with Staff C, he/she stated that he/she forgot to do the 3:00 a.m. rounds due to being so busy. As they were walking in the door, the phone rang from the daughter of Resident #1, who told them to check Resident #1. They found Resident #1 on the floor by his/her bedside lying on his/her back.<br><br>A review of a written statement from Staff C showed that he/she reiterated what occurred when he/she made rounds with Staff B. Staff B stated both of them made rounds on all MC residents just after 12:00 a.m. including Resident #1. Both staff were busy attending to the resident in room #162. Staff C stated that he/she did not realize how late it was and he/she returned to the MC with Staff B and missed the 3:00 a.m. rounds. The phone rang, and when Staff B answered, AA informed him/her about the situation Resident #1 was in. Staff C stated both of them immediately went down to the room of Resident #1 and found him/her lying on the floor right beside his/her bed.<br><br>A review of law enforcement's supplemental narrative report showed that on 5/7/21, Staff B and Staff C were interviewed regarding the incident. It was noted that Staff B and Staff C admitted that they were playing games on their phones, and they missed doing their rounds every two hours in the MCU.<br><br>During an interview on 5/12/21, Resident #1 was unable to respond verbally to questions but could nod his/her head yes or no in response to direct questions. Resident #1 nodded his/her |

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head yes when asked if he/she had a fall. Resident #1 shook his/her head no when asked about injuries from the fall. Resident #1 nodded his/her head no when asked if anyone had come in to check on him/her after having the fall.

During an interview on 6/9/21 at 2:38 p.m., AA stated that he/she watched video footage of the resident the morning of 4/20/21. AA stated that he/she did not see Resident #1 in his/her bed so he/she had to rewind the video footage. AA stated that he/she saw that Resident #1 had fallen and was on the floor the whole night, and no one came to check on him/her. AA stated that he/she called the facility and spoke with Staff B to let him/her know that they needed to check on Resident #1. AA stated that he/she later arrived at the facility. AA stated that he/she questioned the staff about why Resident #1 was not checked, Staff C did not give a reason. AA stated that Staff B and Staff C, were arrested, and both were out on bond. AA stated that he/she assessed Resident #1 for injuries with the two day shift staff, and he/she had a bruise on his/her hip. AA stated that he/she heard that one of the staff members later admitted to the police that they were playing games on their phones all night. AA stated that when he/she arrived at the facility that morning, he/she also found urine and feces on the floor, which he/she had to clean up. AA also stated that Resident #1 did not have underwear while on the floor. AA stated that when the resident used the restroom, he/she removed his/her underwear and left them in the bathroom.

A review of the file for Resident #1, admitted 10/24/20, showed diagnoses of late onset Alzheimer's disease and coronary artery disease.

A review of files for Staff B and Staff C showed they were terminated on 4/22/21, as a result of suspected neglect of a resident.

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