February 16, 2021

In response to a recent survey, the following is a plan of correction. Please note: the official, written report has not yet been received, and the information below is based on a verbal report from Rachel Barevich, BSW from the State of Georgia, Department of Community Health.

Not reporting daily to DCH site regarding Covid 19:

DCH site to be updated daily beginning February 4, 2021.

Proper infection control procedures not followed:

All direct care team and supervisors to be re-trained on proper infection control procedures by April 30, 2021.

Did not follow proper Covid procedures and quarantine protocol:

Retraining and review of proper Covid protocols for VPRX and President by Director of Compliance to be completed by February 5, 2021

Jennifer Mohler | Community President
The Social at Savannah

the Social
BY THRIVE
SAVANNAH

Plan of Correction for December 9, 2020

1. *Staffing POC*:
    - Effective immediately, adequate staffing, will be provided to resident in Building B, with the resident that is on quarantine for COVID 19 precautions.
    - Utilize staffing agencies when needed.

2. *Temperature/Space Heater POC*:
    - Effective immediately, removed space heaters from building. – completed 12/9/20
    - Fire Marshal will be contacted to get written authorization to utilize space heaters. Fire marshal contacted 12/9/2020 awaiting response.
    - Ensure all doors are open in building B, if internal doors gets shut team member will open immediately upon discovery of door being closed.
    - Team member education on ensuring all internal room doors stay open in building B and immediately open if discover they are shut, team to notify maintenance or front desk immediately if temperature falls below 63 degrees F in B building.

Tammy Claridge, RN

Tammy Claridge, RN

Vice President of Resident Experience

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor | Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

May12, 2021

VIA CERTIFIED MAIL (7009 2820 0004 3959 7461)
David Jones, Registered Agent
Savannah Commons Operating Company, LLC
d/b/a Savannah Commons
3527 Walton Way Ext
Augusta, Georgia 30909

VIA REGULAR MAIL
Jennifer Mohler, Administrator
Savannah Commons
1 Peachtree Drive
Savannah, Georgia 31419

RE: NOTICE OF INTENT TO IMPOSE FINE

Mr. Jones and Ms. Mohler:

On December 15, 2020, staff from the *Department of Community Health, Healthcare Facility Regulation Division, Personal Care Home Program (hereinafter, the "Department")* completed an investigation at **Savannah Commons, located at 1 Peachtree Drive, Savannah, Chatham County, Georgia 31419**.

As a result of this investigation, the Department has cited your facility with five (5) violations of the *Rules and Regulations for Assisted Living Communities, Chapter 111-8-63.* A copy of the inspection report is attached hereto as Exhibit "A" and incorporated by reference in this notice.

The investigative survey found that the facility was not in substantial compliance with the *Rules and Regulations for Assisted Living Communities, Chapter 111-8-63,* and that the conditions in the facility constituted one (1) initial Category I violation , and one (1) repeat Category I violation.

A Category I violation is a violation or combination of violations of licensing requirements which has caused death or serious physical or emotional harm to a person or persons in care or poses an imminent and serious threat or hazard to the physical or emotional health and safety of one or more persons in care.

Pursuant to the *Rules and Regulations for Assisted Living Communities, Chapter 111-8-63, and the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, Chapter 111-8-25*, you are hereby notified of the Department's intent to impose

a fine of $1,201.00 for one (1) initial Category I violation, and $2,000.00 for one (1) repeat Category I violation, for a total fine amount of $3,201.00. The violation for which the Department is imposing a fine are attached hereto and marked with asterisks on Exhibit "A". Copies of the investigation reports showing that this violation was previously cited are attached as Exhibits "B" and "C" and incorporated by reference in this notice.

Pursuant to O.C.G.A. § 31-2-8(c) and O.C.G.A. § 50-13-13 , you have the right to contest this action by filing a request for an administrative hearing before an Administrative Law Judge with the Office of State Administrative Hearings.

Your request for a hearing must be made in writing and must be submitted by email to **hfrd.legal@dch.ga.gov** or submitted by mail **no later than ten (10) calendar days from the date of your receipt of this notice and addressed to:**

Mr. Shariyf Muhammad, Esq.
Healthcare Facility Regulation Division
Department of Community Health
2 Peachtree Street, N.W., Suite 31.447
Atlanta, Georgia 30303-3167
Email: hfrd.legal@dch.ga.gov

A hearing request stays or suspends the imposition of the fine until the hearing is conducted and a final decision has been rendered by the Administrative Law Judge.

If you do not request a hearing within ten (10) days of your receipt of this notice, the decision to impose the fine of $3,201.00 will be final. Payment of the fine by certified check or money order would then be expected within twenty (20) days of your receipt of this notice. The certified check or money order should be made payable to the *Department of Community Health* and mailed to the above-address. If the licensee does not pay the penalty as finally determined by the Department, the license to operate the facility may be revoked, a civil lawsuit to collect the fine may be brought against the licensee by the Attorney General or his designee, or another civil penalty may be imposed.

This letter also serves as notice that failure to correct cited deficiencies or failure to maintain compliance once corrections are made may result in further sanctions, including revocation of your permit.

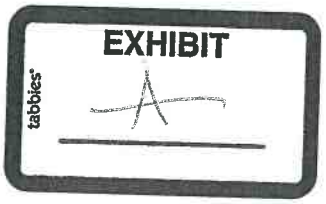
Should you have any questions concerning this matter, please do not hesitate to contact me at 404-657-5850.

Sincerely,
Shirley Rodrigues
Shirley Rodrigues, Director
Personal Care Home Program
Healthcare Facility Regulation Division
Enclosures: (3)
cc: Melanie Simon, Shariyf Muhammad, Melanie McNeil,Tina Lawrence, Facility File

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
	ALC000603	A. BUILDING: _____ B. WING _____	12/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COMMONS	1 PEACHTREE DRIVE SAVANNAH, GA 31419

(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 #GA00210296. The investigation started on 12/8/2020 and was completed on 12/15/2020. An on-site visit was made on 12/9/2020.	L 000		
L 701 SS=K	111-8-63-.07(2) Owner Governance. The governing body is responsible for implementing policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to implement policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. Findings include: A review of the facility's policies and procedures (P&P) under "Disruption in the Utility Service Emergency Plan" on 12/10/20 showed the following; 1. The physical plant manager will ensure that the air temperatures are maintained at a safe temperature (62-84 degrees). 2. If temperatures are out of this range. residents should be moved to a safe location 3. The person in charge on shift should report the problem to the physical plant manager who will check the system and notify a contractor if	L 701		

State of GA, Healthcare Facility Regulation Division

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L 701	Continued From page 1 necessary 4. All doors to all rooms should remain open if the outage is in the common area 5. If the heating is affected maintenance will provide a heating system approved by the local fire inspector 6. During the time the heating system is in use Team members should be present 24 hours a day and should maintain a safety log consisting of hourly checks and signatures. The facility is an Assisted Living Community with Memory Care. The memory care section had three (3) separate buildings (buildings A, B, and C) with a central courtyard. The B building was designated as the isolated COVID 19 building. Resident #1 was the only resident in B Building B in a 12 separate bedrooms, a central living/dining area and kitchenette. During a tour of the facility on 12/9/2020 at 9:20 a.m., Resident #1 was walking with a private duty sitter. Also observed were space heaters. One space heater was turned on and in use, located on the counter of the kitchenette in the central community room. An electric fireplace was on the far side of the living room, turned off. A space heater was turned off in the bedroom of Resident #1. The facility thermostat showed 65 degrees Fahrenheit (F) in the community room. Using a Spier Scientific laser thermometer the air coming from the ceiling vent in the common area was measured 64 degrees F. The temperature in the bedroom of Resident #1 using the same laser thermometer registered 61.2 degrees F. This was all witnessed and confirmed by Staff C, Maintenance Supervisor. During an interview 12/8/20 HH stated Resident #1 had been moved from one building to another	L 701		

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L 701	Continued From page 2 building in the memory care, and was the only resident there. There were periods when no staff were in the building. Resident #1 had private duty caregivers, hired by a guardian. There was no heat in the building. A photo of the thermostat taken by one of the caregivers showed a thermostat reading of 61 degrees farenheit (F) in the building. HH stated Resident #1 was moved to this building because he/she had a positive COVID test result, then 2 rapid tests came back negative. During an interview on 12/9/20, Staff C stated he/she was informed on 12/7/2020, that the heating system in the B Building was not working. The unit that needed repair was the area that heated the common area of this building. Each bedroom had its own heating unit. Staff C stated he/she did not know why the bedroom of Resident #1 was so cold. Staff C stated he/she would move Resident #1's bed into another room where the heat was working immediately. Staff C stated staff should have noticed it was cold in the resident's bedroom and moved the bed earlier. Staff C stated the local Fire Marshal (FM) had not been notified, and no approval had been received from the Fire Marshal's office prior to using space heaters in the building. During an interview on 12/9/20 at 9:30 a.m., Staff B stated he/she was aware that maintenance was working on the heating unit in Building B. The heat was working in each bedroom of that building and staff were supposed to keep all the bedroom doors open so the heat could go out into the common area. Staff B stated Resident #1 liked to walk around in the building closing doors. Staff B confirmed there was no staff in the building to ensure the doors were reopened.	L 701		

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L 701	Continued From page 3 The facility contacted the FM after staff from the Department was onsite for the investigation and as a part of the facility's Emergency Plan of Correction. Following this contact, Staff C sent an email to staff from the Department on 12/9/20 at 3:56 p.m. to show that the FM had approved the use of electricspace heaters in B building while there was only one (1) resident in the building on 12/9/20 at 3:50 p.m. This approval was through 12/13/20, the expected date when repairs to heating system was to be completed. Staff was to keep a record of a fire watch for documentation purposes. Cross reference to 1305 and 2501.	L 701		
L1305 SS=J	111-8-63-.13(5) Community Safety Precautions. Space heaters must not be used, except during an emergency situation after obtaining specific written approval of the fire safety authority having jurisdiction over the assisted living community. This RULE is not met as evidenced by: ****>>>>Based on record review, observation and interview, the facility failed to ensure space heaters were not used, except during an emergency situation after obtaining specific written approval of the fire safety authority having jurisdiction over the assisted living community. Findings include: The facility had a memory care unit (MCU). The memory care unit had 3 separate buildings (A, B, C) with a central courtyard. The B building facility was esignated as the isolation for COVID	L1305		

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L1305	Continued From page 4 19 residents. Resident #1 was the only resident in B building with 12 separate bedrooms. During a tour of the B building on 12/9/20 at 9:20 a.m., Resident #1 was walking with his/her private duty sitter. There were no facility staff observed in the facility. There were space heaters observed in the B building,. One space heater was in use placed on the counter of the kitchenette in the central community room. The facility thermostat showed it was 65 degrees F in the community room. Using a Spier Scientific laser thermometer the air coming from the ceiling vent in the common area was measured to be 64 degrees F. The temperature in Resident #1's bedroom, using the same device, was 61.2 degrees F. This was all witnessed and confirmed by Staff C, Maintenance Supervisor. During interview 12/9/21 GG stated it had been cold in the building and in Resident #1's bedroom. During an interview on 12/9/20, Staff C stated he/she was informed on Monday 12/7/20 that the heat in this building was not working and needed repair. Staff C stated that each bedroom had its own heating unit and he/she did not know why Resident #1's bedroom was so cold. Staff C stated he/she would immediately move Resident #1's bed into another room where the heat was working. Staff C stated staff should have noticed it was cold in the resident's bedroom and moved the bed earlier. Staff C stated the local fire marshal had not been notified nor had approval been obtained from the fire marshal's office prior to using space heaters in the building. During interview on 12/9/20 at 9:30 a.m., Staff B stated he/she was aware maintenance was working on the heating unit in Building B. The	L1305		

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L1305	Continued From page 5 heat was working in each bedroom and staff were supposed to keep all the bedroom doors open so the heat could go out into the common area. However, Resident #1 liked to walk around in the building closing doors. Staff B confirmed there was no staff in the building to ensure the doors were reopened or to ensure the space heaters were being used in a safe manner. During telephone interview at 11:30 a.m. Staff B acknowledged that staff in Building A and Building C or in the courtyard could not observe Resident #1 and would not know if the resident had an emergency. A review of the file for Resident #1 showed an admission date of 7/10/17 with diagnosis of severe Alzheimer's Disease.The Resident Needs Evaluation dated 10/1/20 showed Resident #1 had severly impaired decision making skills. Resident #1 had a history of falls and needed increased safety checks frequently throughout the shift.	L1305		
L1905 SS=D	111-8-63-.19(1)(a)6. Additional Req for Spec Memory Care Units. The assisted living community must include in its licensed residential care profile an accurate written description of the special care unit that includes the following: ... 6. staffing patterns, including the ratio of direct care staff to resident for a 24-hour cycle, and a description of how the staffing pattern differs from that of the rest of the program; ... This RULE is not met as evidenced by: >>>>Based on record review and interview, the	L1905		

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L1905	Continued From page 6 facility failed to include in its memory care policies and procedures an accurate written description of the special care unit that includes staffing patterns, including the ratio of direct care staff to resident for a 24-hour cycle, and a description of how the staffing pattern differs from that of the rest of the program. Findings include: A review of an email received 12/14/20 from Staff B, showed the facility did not have a staffing policy for the memory care unit. During an interview on 12/10/20, Staff B stated it was their policy to staff the facility at a ratio of 15 residents per one(1) staff member during the day and 25 residents per one(1) staff member for night time. This was for the assisted livng area and memory care. Staff B stated he/she thought it was alright not to have a staff member in Building B with Resident #1. Staff B stated staff working in Building A and Building C would not be able to observe Resident #1 and respond if there was an emergency.	L1905		
L1924 SS=J	111-8-63-.19(1)(c)2. Staffing and Initial Staff Orientation. [The assisted living community must ensure:] ... 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. ... This RULE is not met as evidenced by: ****>>>>Based on record review, observation and interview, the facility failed to ensure at least one staff member who is awake and supervising the unit at all times and sufficient numbers of trained	L1924		

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L1924	Continued From page 7 staff on duty at all times to meet the needs of the residents. Findings include: A review of the file for Resident #1 showed, admitted 7/10/17 with diagnosis of severe Alzheimer's Disease. The Resident Needs Evaluation dated 10/1/20 showed Resident #1 had severly impaired decision making. Resident #1 had a history of falls and needed increased safety checks frequently throughout the shift. Observation on 12/9/20 at 9:20 a.m., upon entering Building B, showed Resident #1 walking with a person who later identified themselves as a private duty sitter. There was no staff member in the building. During interview, GG stated there was not a staff member in the building at that time. GG stated a staff member had been there but left about 15 minutes earlier. GG stated Resident #1 had sitters 24 hours daily, 7 days a week hired by the guardian. During an interview, Staff B stated there was not a staff in Building B with Resident #1 and there were no staff assigned to work Building B for any shift. Staff B thought it was alright because the resident had private sitters. Staff B acknowledged staff working in Buildings A and C could not observe Resident #1 in Building B and would not know if there was an emergency. Staff B stated the staff who had been in the building earlier was the medication aide who gave medications to residents in the 3 buildings and only came when Resident #1 needed medications.	L1924		

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L2501	Continued From page 8	L2501		
L2501 SS=L	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 1 residents (Resident #1). Findings include: This is an ALC with memory care. The memory care is a walled area that encloses 3 separate buildings (buildings A, B, C) and a central courtyard. The facility had designated B building as the isolated COVID building. Resident #1 was the only resident in Building B which has 12 separate bedrooms, a central living/dining area and kitchenette. Observation on 12/9/20 at 9:20 a.m., upon entering Building B, showed Resident #1 walking with a person later who identified themselves as a private duty sitter (GG). Also observed during a tour of the facility were space heaters. Observation showed one space in use, was located on the counter of the kitchenette in the central community room. An electric fireplace was on the far side of the living room not in use. A space heater was observed in Resident #1's bedroom. The space heater was turned off. The facility thermostat showed it was 65 degrees F in the community room. Using a Spier Scientific laser thermometer the air coming from the ceiling vent in the common area was measured to be 64	L2501		

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L2501	Continued From page 9	L2501		

degrees F. Measuring the temperature at shoulder lever the temperature was 72.2 degrees F. The temperature in Resident #1's bedroom, using the same device, was 61.2 degrees F. This was all witnessed and confirmed by Staff C, Maintenance Supervisor.

During an interview 12/8/20 HH stated Resident #1 had been moved from one building to another building in the memory care, he/she was the only resident. There were periods when no staff were in the building. Resident #1 had private duty caregivers, hired by guardian. There was no heat in the building. One of the caregivers sent the complainant a photo of the thermostat showing 61 degrees farenheit (F) in the building. HH stated Resident #1 was moved to this building because he/she had a positive COVID test result, then 2 rapid tests came back negative.

During an interview on 12/9/20, Staff C stated he/she was informed on Monday, 12/7/20 that the heat in this building was not working. A repair company came out on Monday and found the heating unit needed a coil, a major repair, the part would have to be ordered. The unit that needed repair was the unit that heated the common area of this building. Each bedroom had its own heating unit. Staff C stated he/she did not know why Resident #1's bedroom was so cold. Staff C stated he/she would move Resident #1's bed into another room where the heat was working. Staff C stated staff should have noticed it was cold in the resident's bedroom and moved the bed earlier. Staff C stated the local fire marshal had not been notified nor asked for approval of the use of space heaters in the building.

During interview on 12/9/20 at 9:30 a.m. Staff B stated he/she was aware maintenance was

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L2501	Continued From page 10 working on the heating unit in Building B. The heat was working in each bedroom and staff were supposed to keep all the bedroom doors open so the heat could go out into the common area. Staff B stated Resident #1 liked to walk around in the building closing doors. Staff B confirmed there was no staff in the building to assure the doors were reopened or to assure the space heaters were being used in a safe manner. During telephone interview at 11:30 a.m. Staff B stated the facility had the required amount of staff on property to meet state guidelines. Staff B then acknowledged that staff in Building A and Building C or in the courtyard could not observe Resident #1 and would not know if the resident had an emergency. A review of document received on 12/9/20 in email from Staff C showed the local Fire Marshal (FM) approved use of electric space heaters in B building while there was only one resident in the building. This approval was through 12/13/20, the expected date when repairs to heat were to be completed. A review of the file for Resident #1 showed, admitted 7/10/17 with diagnosis of severe Alzheimer's Disease. The Resident Needs Evaluation dated 10/1/20 showed Resident #1 had severly impaired decision making. Resident #1 had a history of falls and needed increased safety checks frequently throughout the shift. This rule was previously cited 11/13/20, 10/2/20 .	L2501		

The Social at Savannah
Plan Of Correction
State Investigation, Intake #GA00209218
Completion date 11/13/2020

POC implementation date: Immediate or by December 13, 2020

Tag: L 0701, SS=J: Facility failed to implement policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with the rules.

POC:

1. All residents upon admission shall receive an individual plan of care, including, but not limited to, a plan for care staff to support the resident's activities of daily living, proper documentation and administration of medications, individual choices regarding food, shower times and an interest inventory to engage residents in activities that are purposeful and fulfilling to each individual resident. Documents to be kept in resident chart.
2. Residents will be assigned a cleaning day by housekeeping.
3. Rooms shall be tidied daily (by care team) and deep cleaned weekly (by housekeeping).
4. In the event the resident refuses staff entry for care or cleaning, a care conference shall be set up with resident and POA/legal surrogate, if applicable. The purpose of that meeting will be to review the facility, resident handbook whereby the above are outlined. Refusal to comply will result in a 30 day move out notice, as it inhibits the staff's ability to maintain a clean, safe and habitable environment for the resident, as well as give the proper and appropriate care to the resident, as outlined in their plan of care.
5. Documentation of care conference will be kept in the resident chart.
6. Care team members, nurses and med techs will receive education on all the above and proof of in-service will be kept in staff files.

Tag: L 1132, SS=J: Facility failed to comply with applicable fire and safety rules published by the Office of the Safety Commissioner.

POC:

1. Effective immediately, all fire drills shall include a list of all participating staff, residents, guests and any support services that are in the facility at the time of the drill. Property Experience

Team to be in-serviced on changes and documentation of all drills will be kept on file and readily accessible.
2. In-service shall be documented for proof of completion.

Tag: L 1300, SS=J: Facility failed to ensure the interior of the assisted living community was kept clean, in good repair and maintained free of unsanitary or unsafe conditions which might pose a health or safety risk to the residents and staff.

POC:

1. Residents will be assigned a cleaning day by housekeeping.
2. Rooms shall be tidied daily (by care team) and deep cleaned weekly (by housekeeping).
3. In the event the resident refuses staff entry for cleaning or preventive maintenance, a care conference shall be set up with resident and POA, if applicable. The purpose of that meeting will be to review the facility, resident handbook whereby the above are outlined. Refusal to comply will result in a 30 day move out notice, as it inhibits the staff's ability to maintain a clean, safe and habitable environment for the resident and staff.
4. Documentation of the above will be kept in the resident chart.

Tag: L 1514, SS=J: Facility failed to ensure in the event a resident develops a significant change in physical or mental condition, the assisted living community must obtain medical information necessary to determine that the resident continues to meet the retention requirements and the assisted living community is capable of meeting the resident's needs.

POC:

1. When a resident presents with a change of condition, a re-assessment will be done by facility nurse and documented in the chart. POA/legal surrogate, if any, and/or resident's physician will be notified and documented in resident chart. If physician orders are given, those will be placed in the chart and implemented upon receipt.
2. In the event the resident refuses care or for information to be given to appropriate parties, EMS shall be contacted to transport resident to hospital where appropriate and necessary care can be given.

Tag: L 1612, SS=J: Facility failed to provide the resident and representative or legal surrogate, if any, with a signed copy of the agreement. A copy signed by both parties (resident and the administrator or on-site manger) must be retained in the resident's file and maintained by the administrator or on-site manger of the assisted living community.

POC:

1. All residents will have a fully executed lease agreement kept in the resident's business office file.
2. All current resident files will be audited for executed lease agreements. Any missing agreements will be in place on or before February 1, 2021, as this administration is limited to the documentation that is currently available and may not have access to documents from previous administrations/ownership.

Tag L 2512, SS=J: Facility failed to ensure each resident had the right to be free from neglect.

POC:

1. All residents upon admission shall receive an individual plan of care, including, but not limited to, a plan for care staff to support the resident's activities of daily living, proper documentation and administration of medications, individual choices regarding food, shower times and an interest inventory to engage residents in activities that are purposeful and fulfilling to each individual resident. Documents to be kept in resident chart.
2. In the event the resident refuses staff entry for care, a care conference shall be set up with resident and POA, if applicable. Documentation of care conference will be kept in the resident chart.
3. When a resident presents with a change of condition, a re-assessment will be done by facility nurse and documented in the chart. POA and/or resident's physician will be notified and documented in resident chart. If physician orders are given, those will be placed in the chart and implemented upon receipt.
4. In the event the resident refuses care or for information to be given to appropriate parties, EMS shall be contacted to transport resident to hospital where appropriate and necessary care can be given.

Tag L 2600, SS=J: The facility failed to ensure that in case of an accident or sudden adverse change in a resident's condition or adjustment, immediate actions appropriate to the specific circumstances were taken to address the needs of the resident, including notifying the representative or legal surrogate, if any. The assisted living community must retain a record of all such adverse changes and the assisted living community's response in the resident's files.

POC:

1. When a resident presents with an accident or sudden adverse change of condition, POA, legal surrogate, if any and/or resident's physician will be notified and documented in resident chart. If physician orders are given, those will be placed in the chart and implemented upon receipt.
2. In the event the resident refuses care or for information to be given to appropriate parties, EMS shall be contacted to transport resident to hospital where appropriate and necessary care can be given.

Tag L 2800, SS=J: The facility failed to ensure the administrator or on-site manager of the assisted living community initiated an immediate transfer to an appropriate setting if the resident developed a physical or mental condition requiring continuous medical care or nursing care.

POC:

1. When a resident presents with a change of condition, requiring continuous medical or nursing care, administrator or on-site manager shall contact EMS to transport resident to hospital where appropriate and necessary care can be given. If the situation is not an emergency, resident, POA (if applicable) and resident's physician shall be notified to assist in proper placement of an appropriate setting. Facility administrator and nurse will also assist in securing appropriate placement as directed by resident's physician.
2. Documentation of all above efforts will be kept in the resident chart.

Tag L 1709, SS=J: Facility failed to provide evidence of the care plan being updated at lest annually and more frequently where the needs of the resident change substantially.

POC:

1. All residents will have, at a minimum, an annual re-assessment or at any significant change of condition where resident's needs require re-evaluation and adjustments to the care plan are necessary.
2. All above documentation will be maintained in the resident's chart.

Tag L 2311, SS=J: Facility failed to clean the resident's private living spaces periodically and as needed to ensure that the space does not pose a health hazard.

POC:

1. Residents will be assigned a cleaning day by housekeeping.
2. Rooms shall be tidied daily (by care team) and deep cleaned weekly (by housekeeping).
3. In the event the resident refuses staff entry for cleaning, a care conference shall be set up with resident and POA, if applicable. The purpose of that meeting will be to review the facility, resident handbook whereby the above are outlined. Refusal to comply will result in a 30 day move out notice, as it inhibits the staff's ability to maintain a clean, safe and habitable environment for the resident, as well as give the proper and appropriate care to the resident, as outlined in their plan of care.
4. Documentation of care conference shall be kept in the resident chart.

Tag L 2501, SS=K: Facility failed to ensure that each resident received care and services which were adequate, appropriate, and in compliance with state law and regulations.

POC:

1. All residents upon admission shall receive an individual plan of care, including, but not limited to, a plan for care staff to support the resident's activities of daily living, proper documentation and administration of medications, individual choices regarding food, shower times and an interest inventory to engage residents in activities that are purposeful and fulfilling to each individual resident. Documents to be kept in resident chart.
2. In the event the resident refuses staff entry for care, a care conference shall be set up with resident and POA, if applicable. Documentation of care conference will be kept in the resident chart.
3. When a resident presents with a change of condition, a re-assessment will be done by facility nurse and documented in the chart. POA and/or resident's physician will be notified and documented in resident chart. If physician orders are given, those will be placed in the chart and implemented upon receipt.
4. In the event the resident refuses care or for information to be given to appropriate parties, EMS shall be contacted to transport resident to hospital where appropriate and necessary care can be given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000603	A. BUILDING B. WING	11/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COMMONS	1 PEACHTREE DRIVE SAVANNAH, GA 31419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{L 0000}	>>>>The purpose of this visit was to investigate intake #GA00209218. The investigation was started on 11/2/20. An on-site visit was made 11/4/20 and the investigation was completed 11/13/20.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{L 0701} SS= J	****>>>>Based on record review and interview, the facility failed to implement policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. Findings include: A review on 11/3/20 of the Law enforcement (LE) report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. The LE report showed the following observation made by NN while in the room of Resident #1 and staff statements: 1. Staff A reported to NN that Resident #1 refused his/her medications and meals. 2. NN could smell feces that permeated from the hallway outside the apartment. 3. Upon entering the apartment, NN was overwhelmed with the smell of feces. Piles and piles of random stuff was scattered around the apartment, piled so high and thick, there was a single width path throughout the apartment. 4. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the room. 5. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. 6. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her.

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	7. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined that Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. 8. A 10-13 order was completed, authorizing transport to the hospital. On 10/23/20 NN visited the facility where Resident #1 was receiving care. Resident #1 continued to be paranoid and delusional and was being treated for pneumonia, chronic obstructive pulmonary disease, diabetes and possible heart problems. A review of facility policies and procedures (P&P) showed the following information: 1. "Services Included in Monthly Residency Fee (Basic Services). Team members will provide supervision in areas of nutrition, medication assistance by certified Team Members and activities of daily living. In addition, the Community will, at its cost, maintain the suite and common areas in good repair. 2. "Additional Services, Housekeeping and Laundry" Housekeeping and laundering of both linens and personal laundry are provided weekly and include basic services. 3. "Resident Assessment and Re-Assessment Process" The Executive Director will have final approval regarding the move-in decision and or continued stay in accordance with regulatory requirements. Frequency of Assessments at least twice a year, at a significant change of condition and re-assessments may be conducted at any time, based on resident status. . 4. Policy "Medication Management Program Guidelines" "Discontinued Medications" Upon receipt of a physician's order to discontinue a medication, the Health and Wellness Director or medication staff will: Transcribe the order on the resident's MAR. Document the information in the resident's wellness file. Notify the pharmacy. A review of the file for Resident #1 showed no documentation that staff had called a physician or pharmacy to see when medications had been discontinued or why. There was no documentation that the facility had contacted the emergency contact listed on the face sheet. There was also no documentation that staff entered the apartment of Resident #1 to assess if there were any fire safety or health hazard issues. There was no admission agreement between Resident #1 and

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the current governing body.

A review of the "Resident Needs Evaluation and ISP" dated 10/15/20 for Resident #1 showed that this was signed and completed by Staff D. Staff D assessed Resident #1 with the following:

Decision Making Impaired
Shower Assistance Refused
Dressing Independent
Dining Independent
Continence Unsure, will not let anyone in his/her room
Continence Management Refused any type of care
Ambulation Independent
Medication No Medicaiton Orders
Bathing/dressing Independent with bathing

During an interview 11/4/20 Staff D stated Resident #1 had stopped opening the door 3 weeks prior to 11/4/20. Resident #1 had stopped letting housekeeping go into apartment some time ago. Staff D did not know if Resident #1 lost weight because the resident always wore large moo-moo dresses and it was hard to tell his/her shape.

During an interview 11/12/20, Staff D stated he/she completed the assessment for Resident #1 on 10/15/20. Staff D stated he/she had not seen Resident #1 for several days prior to 10/15/20 and did not see him/her on the day of assessment. Staff D stated spoke to Resident #1 through the closed apartment door. Staff D stated he/she assessed Resident #1 as independent in bathing and dressing. Staff D stated that he/she had seen the resident in the past when he/she had on different clean gowns and was groomed.

During an interview 11/12/20, Staff B stated he/she was hired on 10/5/20. Staff B stated he/she did not try to contact Resident #1's emergency contact or physicians listed on the last MAR or history and physical when he/she became aware Resident #1 had barricaded the apartment door, was not accepting facility food and did not take medications. Staff B stated there had not been a nurse in his/her position for awhile so the governing body had sent nurses from other facilities to help out. They were aware of the situation with Resident #1 but it did not appear they had done anything to help the resident.

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{L 1132} SS= J	****>>>>Based on record review and interview, the facility failed to comply with applicable fire and safety rules published by the Office of the Safety Fire Commissioner. Findings include: A review of fire evacuation drills conducted between 9/30/19 and 2/14/20 showed drills were conducted on the following dates and times: 9/30/19 1:48 p.m. 10/13/19 3:00 p.m. 11/29/19 11:15 p.m. 1/14/20 3:05 p .m.

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	2/14/20 10:30 a.m. There was no indication on the conducted reports of which residents, if any, participated in the fire evacuation drills. During an interview 11/13/20, Staff A stated he/she could not locate any lists of residents who participated in the fire drills and had no knowledge if residents actually did participate.
{L 1300} SS= J	****>>>>Based on observation, record review and interview the facility failed to ensure the interior of the assisted living community was kept clean, in good repair and maintained free of unsanitary or unsafe conditions which might pose a health or safety risk to the residents and staff. During observation on 11/4/20 at 10:30 a.m., the apartment of Resident #1 had terrible odor, even when wearing a mask. Piles of stuffed animals, pillows, and boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window. A review 11/3/20 of police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only

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	concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. During an interview 11/3/20 NN stated he/she was called to the faciity in response to resident having a psychotic event. Upon entering the apartment there was only a path through the apartment. There did not appear to be a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. During an interview on 11/3/20 MM stated he/she and NN pushed their way into Resident #1's apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the ambulance stretcher into the apartment. During an interview 11/2/20 Staff B stated he/she had been employed at the facility about one month. Staff B entered Resident #1's apartment with Staff A and Staff C 10/22/20. They found Resident #1 on the couch. There was feces all over the floor and on Resident #1's feet. The apartment was filled with items to the ceiling. They could not get through to the bathroom. When asked how he/she got to the bathroom, Resident #1 responded he/she would go on the stuffed animals that were all over the apartment. Staff B stated there was evidence Resident #1 had urinated and defecated on the stuffed animals. During an interview 11/3/20 Staff C stated on 10/22/20 he/she went to Resident #1's room and was let in by the resident. Items were blocking the door which needed to be pushed aside. Staff C had just enough room to slide through the door. There were piles of feces on the floor along with dirty towels that appeared to have been used to clean the floor. Resident #1 was lying on the couch in an awkward position. Resident #1 had feces on his her feet. He/she told Staff C it was pudding that someone had thrown on him/her.

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{L 1514} SS= J	****>>>>Based on record review and interview, the facility failed to ensure in the event a resident develops a significant change in physical or mental condition, the assisted living community must obtain medical information necessary to determine that the resident continues to meet the retention requirements and the assisted living community is capable of meeting the resident's needs for 1 of 1 sampled resident (Resident #1). Findings include: A review of the file for Resident #1 showed Resident Needs Evaluations dated 5/19/20 through 10/15/20 detailing Resident #1 was confused, withdrawn, suspicious, refused to be assessed, would not let anyone in his/her room. There were no medication orders. A review of the Facility Observation Notes dated 9/8/20 through 10/15/20 detailed Resident #1 would not eat any food from the faciity dining room, continued to stay barricaded in his/her room, Resident #1 would talk to staff through the door but not let anyone in. 10/12/20 note Staff B reported he/she attempted to see the resident but the apartment door could only be opened 2 inches. A horrible smell was noted. 10/15/20 note reported there were no changes, Resident #1 continued to deny housekeeping access, there was a strong odor, the staff could only get the apartment door open so far. There was no documentation in the file to show that staff had attempted to contact the emergency contact listed in the file or any of the physicians listed on the MAR and physician reports. During an interview 11/3/20 MM, social worker with the police task force stated he/she was called in to evaluate if Resident #1 met criteria to be unwillingly sent to the hospital (10-13). MM worked with a mental health agency that had treated Resident #1 in the past for schizophrenia. MM stated when Resident #1 was seen previously at the agency he/she was able to manage while on medications but was not functional without medication. During this visit, Resident #1 had no idea something was wrong. MM stated he/she and NN pushed their way into the apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on

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	Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the stretcher into the apartment. During an interview 11/12/20 Staff A stated he/she became aware of the situation with Resident #1 the end of 9/2020 or the beginning of 10/2020. Staff A stated he/she did not contact any physician, medical facility or the emergency contact regarding caring for Resident #1. During interview 11/12/20 Staff B stated he/she did not contact any physicians listed on Resident #1's MAR or physician reports. Staff B stated he/she did not know when Resident #1 last took medications, the last MAR he/she could locate was dated 5/2016. .
{L 1612} SS= J	****>>>>Based on record review and interview, the facility failed to provide the resident and representative or legal surrogate, if any, with a signed copy of the agreement. A copy signed by both parties (resident and administrator or on-site manager) must be retained in the resident's file and maintained by the administrator or on-site manager of the assisted living community for 1 of 1 sampled resident (Resident #1). Findings include: A review of Department records showed the facility was granted a permit to operate 6/18/19. A review of the file for Resident #1 showed admission date of 10/19/15. There was no admission agreement between the resident and the current governing body. During an interview 11/9/20, Staff A stated there was no signed admission agreement between Resident #1 and the facility or governing body.

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{L 1709} SS= J	****>>>>Based on record review and interview, the facility failed to provide evidence of the care plan being updated at least annually and more frequently where the needs of the resident changed substantially for 1 of 1 sampled resident (Resident #1). Findings include: A review on 11/3/20 of the file for Resident 1 showed a 10/15/20 "Resident Needs Evaluation and ISP" completed by Staff D. In this evaluation Staff D indicated Resident #1 was independent in bathing, dressing, grooming and dining. Under Continence Staff D indicated he/she was unsure as Resident #1 would not let anyone into the room. Staff D noted under Medication there were no medication orders. Review 11/3/20 of police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. On 10/23/20 NN visited the hospital where Resident #1 was receiving care. Resident #1 continued to be paranoid and delusional and was being treated for pneumonia, chronic obstructive pulmonary disease, diabetes and possible heart problems.

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{L 2311}	During an interview 11/12/20 Staff D , LPN, stated he/she did not see Resident #1 on 10/15/20 when the evaluation was completed. Staff D stated he/she completed the evaluation based on what he/she saw on previous occasions when Resident #1 would open the door. During the 10/15/20 evaluation Staff D spoke to Resident #1 through a closed door. During an interview 11/4/20 Staff D stated he/she had worked at the facility 4 years. Staff D had last seen Resident #1 approximately 1 week prior to day the resident taken to hospital. Staff D stated he/she would go by the apartment daily and could hear Resident #1 talking to him/herself in the apartment. Staff D stated in his/her 4 years at the facilty, Resident #1 had never taken medications. There was never an MAR. Staff D did not know of any doctor visits in the past 4 years. When he/she started working 4 years ago, Resident #1 would come out into the hall to talk to him/her. In the past 3 weeks Resident #1 refused to open the door. In the past month or month and half Resident #1 stopped eating facility food. From the beginning Resident #1 talked about the military spying on him/her. During an interview 11/4/20 Staff F stated he/she had worked at the facility 1 year and 2 months. Staff F was a CNA and CMA. Staff F knocked on the door several times with no response. Staff F would deliver meals and leave the tray on the shelf by the door. Resident #1 eventually took the tray if he/she wanted to eat it. When Staff F began working at the facility, Resident #1 would come out to play the piano or go grocery shopping. Because Resident #1 blocked the door, Staff F could not really open the door. Sometimes the resident would open the door and peek out. When Staff F could see Resident #1, he/she was unkempt, wearing a dirty nightgown, had greasy hair and had body odor. Staff F stated the last time he/she could remember Resident #1 coming out of the apartment was a couple of months ago. During an interview 11/4/20 Staff E stated he/she had worked at the facility over 20 years. Staff E last saw Resident #1 one week prior. The resident's hair was not clean, dress was stained and dirty. Staff E did not look at the resident's feet. When Resident #1 moved in in 2015 Staff E helped him/her bathe and dress. Then the resident began to say the government had told him/her not to get in the water. Staff E stated Resident #1 started to barricade his/her door a few years ago.

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SS= J	****>>>>Based on observation and interview, the facility failed to clean the residents' private living spaces periodically and as needed to ensure that the space does not pose a health hazard for 1 of 1 sampled resident (Resident #1). During observation on 11/4/20 at 10:30 a.m.,the odor in Resident #1's apartment was terrible, even when wearing a mask. Piles of stuffed animals, pillows, boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window. A review on 11/3/20 of police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and was covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. During an interview 11/3/20 NN stated he/she was called to the faciity in response to resident having a psychotic event. Upon entering the apartment there was only a path through the apartment. There did not appear to be a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. During an interview 11/3/20 MM stated he/she and NN pushed their way into Resident #1's apartment. There was barely enough room for 3 people to stand because the apartment was full

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	of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the ambulance stretcher into the apartment. During an interview 11/2/20 Staff B stated he/she had been employed at the facility about one month. Staff B entered Resident #1's apartment with Staff A and Staff C 10/22/20. They found Resident #1 on the couch. There was feces all over the floor and on Resident #1's feet. The apartment was filled with items to the ceiling. They could not get through to the bathroom. When asked how he/she got to the bathroom, Resident #1 responded he/she would go on the stuffed animals that were all over the apartment. Staff B stated there was evidence Resident #1 had urinated and defecated on the stuffed animals. During an interview 11/3/20 Staff C stated on 10/22/20 he/she went to Resident #1's room and was let in by the resident. Items were blocking the door which needed to be pushed aside. Staff C had just enough room to slide through the door. There were piles of feces on the floor along with dirty towels that appeared to have been used to clean the floor. Resident #1 was lying on the couch in an awkward position. Resident #1 had feces on his her feet. He/she told Staff C it was pudding that someone had thrown on him/her.
{L 2501} SS= K	****>>>>Based on record review and staff interview, the facility failed to ensure that each resident received care and services which were adequate, appropriate, and in compliance with state law and regulations for 1 of 1 sampled resident (Resident #1). Findings include: A review of the incident report submitted to the Department dated 10/26/26, showed Resident #1 was having a mental crisis, was unable to care for himself/herself, and needed medical attention. Resident #1 was transferred to the emergency room for evaluation and treatment. During an interview 11/3/20 NN stated he/she was called to the faciity in response to resident having a psychotic event. Upon entering the apartment there was only a path through the

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	apartment. There did not appear to be a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. NN stated there apparently was new management at the facility. They discovered Resident #1 had not paid rent for many, many months, signifying a problem with the resident. NN stated it was apparent Resident #1 had a situation going on for some time, his/her decline did not happen overnight. NN did not understand why staff from the facility did not intervene earlier. A review of the file for Resident #1, admitted on 10/19/15 showed diagnoses of psychotic with delusions. The medications prescribed on admission were the following: Novolog 5 units three times daily before meals Lantus 15 unites at nightly Carvedilol (Coreg) 6.25 mg twice daily for hypertension Donepezil (Aricept) 5 mg at night for dementia Levothyroxine (Levothyroid) 125 mg nightly for hypothyroidism Lisinopril (Prinivl) 10 mg daily for high blood pressure Albuterol 90 (Proventil) 1 puff every 6 hours as needed for asthma or chronic obstructive pulmonary disease A 5/2016 facility Medication Administration Record (MAR) showed all of the above medications were continued plus the following were added: Metformin 500 mg twice daily for diabetes Atorvastatin 20 mg once daily for high cholesterol Furosemide (Lasix) 40 mg once daily for fluid retention Glipizide 5 mg twice daily for diabetes There was no MAR in the file after 5/2016. A review of Resident Needs Evaluations showed the following: 10/15/20 Resident refused any type of care. Continence was unknown, resident would not let anyone into his/her room. There were no medication orders. 10/2/20 Resident was evaluated as confused, withdrawn, easily upset, suspicious, interferes with care.

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	9/22/20 Resident refused to be assessed. 8/21/20 Resident refused to be assessed. 7/3120 Resident refused to be assessed 6/20/20 Resident was non compliant 5/19/20 Resident was assessed as non compliant with psychotic delusions, no medications A review of the facility Observation Notes showed the following: 9/8/20 Resident not eating food from dining room. Stated the army has sprayed the food with poison, has snacks in room 9/22/20 Continues to stay barricaded in his/her room. Will talk to staff through his/her door. Continues to say he/she has food in his/her room. Not accepting food from facility 10/12/20 Staff B noted he/she heard no one was able to see Resident #1 and the resident barricaded the door to his/her room. Attempted to see the resident but could only open the door 2 inches. Resident #1 stated he/she did not need anything. Horrible smell was noted 10/15/20 No changes with resident. Staff was able to see resident through open door. Door would only open a bit so far. Will not let housekeeping come in to clean. Room very odorous. Continues to refuse meals from dining room. A review on 11/3/20 of police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpet was dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. On 10/23/20 NN visited the hospital where Resident #1 was receiving care. Resident #1 continued to be paranoid and delusional and was being treated for pneumonia, chronic obstructive pulmonary disease, diabetes and possible heart problems.

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	During observation on 11/4/20 at 10:30 a.m., the odor in apartment of Resident #1 was so unbearable that the smell permeated even through a mask. Piles at least 4 feet high of stuffed animals, pillows, boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window. During an interview 11/2/20 Staff A stated he/she just recently started working at the facility. Staff A stated Resident #1 had been living in assisted living since 2015. When Staff A started working he/she was told Resident #1 would not let anyone into the apartment. The resident did not take any medications. Meals were left on trays for him/her, in the hallway outside his/her apartment door. Resident #1 did not eat the food the facility provided, telling staff the government had poisoned it. A friend would come monthly and take Resdent #1 out to shop for groceries. Staff A stated he/she tried to see Resident #1 but could only open the apartment door 2 inches, it was blocked. Staff A could talk to Resident #1 but not see him/her. Staff C, who is Staff A's supervisor, visited and was able to coax Resident #1 into opening the door enough to get in. During an interview 11/12/20 Staff A stated he/she was hired 8/24/20. He/she became aware of Resident #1's situation around the end of 9/2020 or beginning of 10/2020. Staff A stated he/she did not attempt to contact Resident #1's emergency contact or any of the physician's listed on the resident's MAR and History and Physical. During an interview 11/2/20 Staff B stated he/she had been employed at the facility about one month. Staff B entered Resident #1's apartment with Staff A and Staff C 10/22/20. They found Resident #1 on the couch. There was feces all over the floor and on Resident #1's feet. The apartment was filled with items to the ceiling. They could not get through to the bathroom. When asked how he/she got to the bathroom, Resident #1 responded he/she would go on the stuffed animals that were all over the apartment. Staff B stated there was evidence Resident #1 had urinated and defecated on the stuffed animals. The smell was horrendous. Resident #1 refused medical care. Staff A called 911 and police responded with a behavior health team. They were able to find Resident #1 incompetent and they sent the resident to the hospital. The contact person listed in the records was a former coworker who had not spoken to Resident #1 in over a year. That person gave Staff A and Staff B the contact information for a sibling of Resident #1 who lived in St. Simons GA. The sibling told them he/she had not spoken to Resident #1 in many years. During an interview 11/3/20 Staff B, R.N, stated there was no current MAR for Resident #1 because the resident did not take any medications. Staff B stated he/she did not know when the

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resident last took medications.

During an interview 11/4/20 Staff B stated he/she could not find any records of doctor visits since 2015 and no records of medications after 5/2016.

During an interview 11/12/20 Staff B stated his/her hire date was 10/5/20. Staff B stated he/she did not try to contact Resident #1's emergency contact or physicians listed on the last MAR or history and physical when he/she became aware Resident #1 had barricaded the apartment door, was not accepting facility food and did not take medications. Staff B stated there had not been a nurse in his/her position for awhile so the governing body had sent nurses from other facilities to help out. They were aware of the situation with Resident #1 but it did not appear they had done anything to help the resident.

During an interview 11/3/20 Staff C stated he/she worked in the corporate office but was at this facility several times over the past few weeks. Staff C stated the week prior to 10/22/20 he/she had gone to Resident #1's apartment. Resident #1 opened the door a few inches and spoke to Staff C. He/she could see into the apartment. There was no feces on the floor or on Resident #1. There was no odor of urine or feces. On 10/22/20 Staff C again went to Resident #1's and was let in by the resident. Items were blocking the door which needed to be pushed aside. Staff C had just enough room to slide through the door. There were piles of feces on the floor along with dirty towels that appeared to have been used to clean the floor. Resident #1 was lying on the couch in an awkward position. Resident #1 had feces on his her feet. He/she told Staff C it was pudding that someone had thrown on him/her. Resident #1 talked about organized crime and snipers trying to kill anyone who came to help him/her. He/she refused when asked if EMS could be called. Staff A called 911 and EMS arrived. When they arrived they did a mini mental evaluation, took blood pressure and temperature. Resident #1 was able to correctly tell them the day, year and who was president. They could not force the resident to go to the hospital. EMT called police task force that specialized in helping the mentally ill. A social worker, a police officer and a negotiator came. Resident #1 gave wild answers and they decided to send Resident #1 to the hospital for a mental health evaluation, against his/her will.

Staff C stated the apartment was packed full of stuff with just pathways to get around.

During an interview 11/3/20 MM stated he/she was a social worker with the police task force and was called in to evaluate if Resident #1 met criteria to be unwillingly sent to the hospital (10-13). MM worked with a mental health agency that had treated Resident #1 in the past for schizophrenia. MM stated when Resident #1 was seen previously at the agency he/she was able to manage while on medications but was not functional without medication. During this visit, Resident #1 had no idea something was wrong. MM stated he/she and NN pushed their way into the apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on

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	the couch and on Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the stretcher into the apartment. During an interview 11/4/20 Staff D, LPN, stated he/she had worked at the facility 4 years. Staff D had last seen Resident #1 approximately 1 week prior to day the resident taken to hospital. Staff D stated he/she would go by the apartment daily and could hear Resident #1 talking to him/herself in the apartment. Staff D stated in his/her 4 years at the facilty, Resident #1 had never taken medications. There was never an MAR. Staff D did not know of any doctor visits in the past 4 years. When he/she started working 4 years ago, Resident #1 would come out into the hall to talk to him/her. In the past 3 weeks Resident #1 refused to open the door. In the past month or month and half Resident #1 stopped eating facility food. From the beginning Resident #1 talked about the military spying on him/her. During an interview 11/4/20 Staff F stated he/she had worked at the facility 1 year and 2 months. Staff F was a CNA and CMA. Staff F had knocked on Resident # 1's door several times with no response. Staff F would deliver meals and leave the tray on the shelf by the door. Resident #1 eventually took the tray if he/she wanted to eat it. When Staff F began working at the facility, Resident #1 would come out to play the piano or go grocery shopping. Because Resident #1 blocked the door, Staff F could not really open the door. Sometimes the resident would open the door and peek out. When Staff F could see Resident #1, he/she was unkempt, wearing a dirty nightgown, had greasy hair and had body odor. Staff F stated the last time he/she could remember Resident #1 coming out of the apartment was a couple of months ago. During an interview 11/4/20 Staff E stated he/she had worked at the facility over 20 years. Staff E last saw Resident #1 one week prior. The resident's hair was not clean, and clothing was stained and dirty. Staff E did not look at the resident's feet. When Resident #1 moved in in 2015 Staff E helped him/her bathe and dress, then the resident began to say the government had told him/her not to get in the water. Staff E stated Resident #1 started to barricade his/her door a few years ago. During an interview OO, previous administrator, stated Resident #1 could not keep a doctor, they would refuse to treat him/her after awhile. OO stated he/she tried to get a psychiatrist to see Resident #1 at the facility. OO called the crisis team. The crisis team told him/her that the resident knew the date, time, year, location, name, current president. They said they could not take the resident to the hospital against his/her will, he/she had the right to refuse treatment and medications. OO stated he/she did not know the last time Resident #1 saw a doctor or took medications. OO stated they tried their best to get help for Resident #1. OO stated he/she called other crisis team professional agencies and no one would help. During an interview 11/5/20 PP, previous DON, stated he/she last worked at the facility mid 2018. PP stated it had been years since Resident #1 took medications or saw a doctor. Staff would

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	make doctor appointments and Resident #1 would refuse to go. Resident #1 had medications and orders when he/she moved in but when those orders ran out Resident #1 did not have orders for refills and would not see a doctor for renewed prescriptions, so 2016 was probably the last time the resident took medications. PP stated they had called the crisis team to come evaluate Resident #1. They said Resident #1 was alert and oriented and they would not take him/her to the hospital. PP stated he/she had called EMS many times but they refused to transport the resident but he/she refused treatment. There was no documentation in the file of Resident #1 to show when or how often staff checked on Resident #1 or tried to encourage the resident to accept help. There was no documentation that staff verified Resident #1 had food available in the apartment on the days the resident refused facility food. There was no documentation the facility had reported to Adult Protective Services to get help for Resident #1. There was no documentation the facility tried to contact Resident #1's emergency contact prior to 10/22/20. There was no documentation the facility attempted to enter the apartment prior to 10/22/20 to assess if a fire hazard or health hazard existed. This violation was previously cited 10/2/20.

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{L 2512} SS= J	****>>>>Based on observation, record review and interview, the facility failed to ensure each resident had the right to be from neglect for 1 of 3 sampled resident (Resident #1). Findings include: During an interview 11/3/20 NN stated he/she was called to the faciity in response to resident having a psychotic event. NN stated when he/she entered the apartment there was only a path through the apartment, including a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. NN stated there apparently was new management at the facility. They discovered Resident #1 had not paid rent for many, many months, signifying a problem with the resident. NN stated it was apparent Resident #1 had a situation going on for some time, his/her decline did not happen overnight. NN did not understand why staff from the facility did not intervene earlier. A review of the file for Resident #1, admitted on 10/19/15 showed diagnoses of psychotic delusions. The following medications were prescribed on admission: Novolog 5 units three times daily before meals Lantus 15 unites at nightly

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	ALC000603	A. BUILDING B. WING	11/13/2020

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Carvedilol (Coreg) 6.25 mg twice daily for hypertension

Donepezil (Aricept) 5 mg at night for dementia

Levothyroxine (Levothyroid) 125 mg nightly for hypothyroidism

Lisinopril (Prinivl) 10 mg daily for high blood pressure

Albuterol 90 (Proventil) 1 puff every 6 hours as needed for asthma or chronic obstructive pulmonary disease

A 5/2016 facility Medication Administration Record (MAR) showed all of the above medications were continued plus the following were added:

Metformin 500 mg twice daily for diabetes

Atorvastatin 20 mg once daily for high cholesterol

Furosemide (Lasix) 40 mg once daily for fluid retention

Glipizide 5 mg twice daily for diabetes

There was no MAR in the file after 5/2016.

A review of Resident Needs Evaluations showed the following information:

:

10/15/20 Resident refused any type of care. Continence was unknown, resident would not let anyone into his/her room. There were no medication orders.

10/2/20 Resident was evaluated as confused, withdrawn, easily upset, suspicious, interferes with care.

9/22/20 Resident refused to be assessed.

8/21/20 Resident refused to be assessed.

7/3120 Resident refused to be assessed

6/20/20 Resident was non compliant

5/19/20 Resident was assessed as non compliant with psychotic delusions, no medications

A review of the Facility Observation Notes showed the following:

9/8/20 Resident not eating food from dining room. Stated the army has sprayed the food with poison, has snacks in room

9/22/20 Continues to stay barricaded in his/her room. Will talk to staff through his/her door. Continues to say he/she has food in his/her room. Not accepting food from facility

10/12/20 Staff B noted he/she heard no one was able to see Resident #1 and the resident

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	barricaded the door to his/her room. Attempted to see the resident but could only open the door 2 inches. Resident #1 stated he/she did not need anything. Horrible smell was noted 10/15/20 No changes with resident. Staff was able to see resident through open door. Door would only open a bit so far. Will not let housekeeping come in to clean. Room very odorous. Continues to refuse meals from dining room. A review of facility documentation showed no documentation of when or how often staff checked on Resident #1 or tried to encourage the resident to accept help. There was no documentation that staff verified Resident #1 had food available in the apartment on the days the resident refused facility food. There was no documentation the facility had reported to Adult Protective Services to get help for Resident #1. There was no documentation of any intervention by the facility, besides calling 911 on 10/22/20. There was no documentation the facility tried to contact Resident #1's emergency contact prior to 10/22/20. There was no documentation the facility attempted to enter the apartment prior to 10/22/20 to assess if a fire hazard existed. A review on 11/3/20 of the police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and was covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. On 10/23/20 NN visited the hospital where Resident #1 was receiving care. Resident #1 continued to be paranoid and delusional and being treated for pneumonia, chronic obstructive pulmonary disease, diabetes and possible heart problems. A review 11/10/20 of 10/22/20 ambulance report showed emergency personnel arrived at the facility 10/22/20 at 1:38 p.m. reported to EMTs Resident #1 was refusing medications, food, drink, showers and having laundry done. Staff reported Resident #1 was having hallucinations. The EMTs found Resident #1 in his/her apartment. The resident had feces on him/her, on the floor, furniture and stuffed animals. Resident #1 was oriented to to date, time and place but was having delusions and hallucinations of snipers. Resident #1 reported he/she had no medical problems, no pain. A mental health evaluation was done by other specialists called to the scene.

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	Resident #1 was determined to be a hazard to self. When EMS staff tried to put Resident #1 in the ambulance he/she became combative and EMS staff administered 2 mg of Ativan. After 5 minutes Resident #1 voluntarily allowed EMS staff to place him/her in the ambulance. Resident #1 was transported to Memorial University Health Hospital at 4:33 p.m. During observation on 11/4/20 at 10:30 a.m., the odor in Resident #1's apartment was terrible, even with a mask on. Piles of stuffed animals, pillows, boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear that there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window. During an interview on 11/2/20 Staff A stated he/she just recently started working at the facility. Staff A stated Resident #1 had been living in assisted living since 2015. When Staff A started working he/she was told Resident #1 would not let anyone into the apartment. The resident did not take any medications. Meals were left on trays for him/her, in the hallway outside his/her apartment door. Resident #1 did not eat the food the facility provided, telling staff the government had poisoned it. A friend would come monthly and take Resdent #1 out to shop for groceries. Staff A stated he/she tried to see Resident #1 but could only open the apartment door 2 inches, it was blocked. Staff A could talk to Resident #1 but not see him/her. Staff C, who is Staff A's supervisor, visited and was able to coax Resident #1 into opening the door enough to get in. During an interview on 11/2/20, Staff B stated he/she had been employed at the facility about one month. Staff B entered Resident #1's apartment with Staff A and Staff C 10/22/20, they found Resident #1 on the couch. There was feces all over the floor and on Resident #1's feet. The apartment was filled with items to the ceiling. They could not get through to the bathroom. When asked how he/she got to the bathroom, Resident #1 responded he/she would go on the stuffed animals that were all over the apartment. Staff B stated there was evidence Resident #1 had urinated and defecated on the stuffed animals. The smell was horrendous. Resident #1 refused medical care. Staff A called 911 and police responded with a behavior health team. They were able to find Resident #1 incompetent and they sent the resident to the hospital. Staff B stated he/she had been told Resident #1's only child was deceased in 2016. The contact person listed in the records was a former coworker who had not spoken to Resident #1 in over a year. That person gave Staff A and Staff B the contact information for a sibling of Resident #1 who lived in another town. The sibling told them he/she had not spoken to Resident #1 in many years. During an interview 11/3/20 Staff B, stated there was no current MAR for Resident #1 because the resident did not take any medications. Staff B stated he/she did not know when the resident last took medications.

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	During an interview 11/4/20 Staff B stated he/she could not find any records of doctor visits since 2015 and no records of medications after 5/2016. During an interview 11/12/20 Staff B stated his/her hire date was 10/5/20. Staff B stated he/she did not try to contact Resident #1's emergency contact or physicians listed on the last MAR or history and physical when he/she became aware Resident #1 had barricaded the apartment door, was not accepting facility food and did not take medications. Staff B stated there had not been a nurse in his/her position for awhile so the governing body had sent nurses from other facilities to help out. They were aware of the situation with Resident #1 but it did not appear they had done anything to help the resident. During an interview 11/3/20 Staff C stated he/she worked in the corporate office but was at this facility several times over the past few weeks. Staff C stated the week prior to 10/22/20 he/she had gone to Resident #1's apartment. Resident #1 opened the door a few inches and spoke to Staff C. He/she could see into the apartment. There was no feces on the floor or on Resident #1. There was no odor of urine or feces. On 10/22/20 Staff C again went to Resident #1's and was let in by the resident. Items were blocking the door which needed to be pushed aside. Staff C had just enough room to slide through the door. There were piles of feces on the floor along with dirty towels that appeared to have been used to clean the floor. Resident #1 was lying on the couch in an awkward position. Resident #1 had feces on his her feet. He/she told Staff C it was pudding that someone had thrown on him/her. Resident #1 talked about organized crime and snipers trying to kill anyone who came to help him/her. He/she refused when asked if EMS could be called. Staff A called 911 and EMS arrived. When they arrived they did a mini mental evaluation, took blood pressure and temperature. Resident #1 was able to correctly tell them the day, year and who was president. They could not force the resident to go to the hospital. EMT called police task force that specialized in helping the mentally ill. A social worker, a police officer and a negotiator came. Resident #1 gave wild answers and they decided to send Resident #1 to the hospital for a mental health evaluation, against his/her will. Staff C stated the apartment was packed full of stuff with just pathways to get around. During an interview 11/3/20 MM stated he/she was called 10/22/20 to evaluate if Resident #1 met criteria to be unwillingly sent to the hospital (10-13). MM stated Resident #1 was seen several years before at a mental health agency that had treated Resident #1 for schizophrenia. MM stated when Resident #1 was seen previously at the agency he/she was able to manage while on medications but was not functional without medication. MM stated he/she and NN pushed their way into the apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the stretcher into the apartment.

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	During an interview 11/4/20 Staff D, LPN, stated he/she had worked at the facility 4 years. Staff D had last seen Resident #1 approximately 1 week prior to day the resident taken to hospital. Staff D stated he/she would go by the apartment daily and could hear Resident #1 talking to him/herself in the apartment. Staff D stated in his/her 4 years at the facilty, Resident #1 had never taken medications. There was never an MAR. Staff D did not know of any doctor visits in the past 4 years. When he/she started working 4 years ago, Resident #1 would come out into the hall to talk to him/her. In the past 3 weeks Resident #1 refused to open the door. In the past month or month and half Resident #1 stopped eating facility food. From the beginning Resident #1 talked about the military spying on him/her. During an interview 11/4/20 Staff F stated he/she had worked at the facility 1 year and 2 months. Staff F was a CNA and CMA. Staff F knocked on the door several times with no response. Staff F would deliver meals and leave the tray on the shelf by the door. Resident #1 eventually took the tray if he/she wanted to eat it. When Staff F began working at the facility, Resident #1 would come out to play the piano or go grocery shopping. Because Resident #1 blocked the door, Staff F could not really open the door. Sometimes the resident would open the door and peek out. When Staff F could see Resident #1, he/she was unkempt, wearing a dirty nightgown, had greasy hair and had body odor. Staff F stated the last time he/she could remember Resident #1 coming out of the apartment was a couple of months ago. During an interview 11/4/20 Staff E stated he/she had worked at the facility over 20 years. Staff E last saw Resident #1 one week prior to 10/22/20. The resident's hair was not clean, dress was stained and dirty. Staff E did not look at the resident's feet. When Resident #1 moved into the facility in 2015 Staff E helped him/her bathe and dress. Then the resident began to say the government had told him/her not to get in the water. Staff E stated Resident #1 started to barricade his/her door a few years ago.

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{L 2600} SS= J	****>>>>Based on record review and interview, the facility failed to ensure that in case of an accident or sudden adverse change in a resident's condition or adjustment, immediate actions appropriate to the specific circumstances were taken to address the needs of the resident, including notifying the representative or legal surrogate, if any. The assisted living community must retain a record of all such adverse changes and the assisted living community's response in the resident's files for 1 of 1 sampled resident (Resident #1). Findings include: A review on 11/3/20 of the LE report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff was scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. A review of the file for Resident #1 provided no documentation to show that any staff attempted to contact the emergency contact listed on the resident's face sheet. There was no documentation to show that staff attempted to call the physician listed on the admitting history and physical and the last MAR. Observation note dated 9/8/20 showed Resident #1 was not eating food provided by the facility, there were snacks in the resident's room. 9/22/20 note showed Resident #1 continued to barricade him/herself in the room. Not accepting any food from the facility. 10/12/20 note by Staff B showed he/she and Staff F attempted to see Resident #1. They were able to push the door open only two inches. They could not see the resident. A horrible smell was noted. During an interview on 11/12/20 Staff B stated his/her hire date was 10/5/20. Staff B stated

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	he/she did not try to contact Resident #1's emergency contact or physicians listed on the last MAR or history and physical when he/she became aware Resident #1 had barricaded the apartment door, was not accepting facility food and did not take medications. Staff B stated there had not been a nurse in his/her position for awhile so the governing body had sent nurses from other facilities to help out. They were aware of the situation with Resident #1 but it did not appear they had done anything to help the resident.
{L 2800} SS= J	****>>>>Based on observation, record review and interview, the facility failed to ensure the administrator or on-site manager of the assisted living community initiated an immediate transfer to an appropriate setting if the resident developed a physical or mental condition requiring continuous medical care or nursing care for 1 of 1 sampled resident (Resident #1). Findings include: A review of the file for Resident #1 showed observation notes (ONs) dated 9/8/20 for Resident #1. The ONs showed that Resident #1 was not eating food provided by the facility. On 9/22/20, Resident #1 continued to barricade him/herself in the room. The resident was not accepting any food from the facility. On 10/12/20, Staff B and Staff F attempted to see Resident #1. They were able to push the door open only two inches, and they could not see the resident. A horrible smell was noted. Further review of the file provided no documentation to show that staff attempted to contact the emergency contact listed on the resident's face sheet. There was also no documentation that staff attempted to call the physician listed on the admitting history and physical and on the last MAR. During an interview 11/3/20, NN stated he/she was called to the facility in response to resident having a psychotic event. Upon entering the apartment there was only a path through the apartment. There did not appear to be a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. NN stated there apparently was new management at the facility. They discovered Resident #1 had not paid rent for many, many months, signifying a problem with the resident. NN stated it was apparent Resident #1 had a situation going on for some time, his/her decline did not happen overnight. NN did not understand why staff from the

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	facility did not intervene earlier. During observation on 11/4/20 at 10:30 a.m., the odor in Resident #1's apartment was terrible, even when wearing a mask. Piles of stuffed animals, pillows, boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window.

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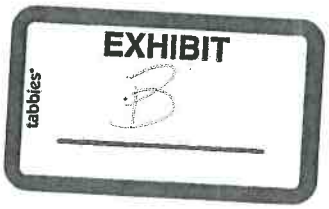
L 000	Initial Comments. >>>>The purpose of this visit was to investigate intake #GA00209218. The investigation was started on 11/2/20. An on-site visit was made 11/4/20 and the investigation was completed 11/13/20.	L 000		
L 701 SS=J	111-8-63-.07(2) Owner Governance. The governing body is responsible for implementing policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. This RULE is not met as evidenced by: ****>>>>Based on record review and interview, the facility failed to implement policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. Findings include: A review on 11/3/20 of the Law enforcement (LE) report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. The LE report showed the following observation made by NN while in the room of Resident #1 and staff statements: 1. Staff A reported to NN that Resident #1 refused his/her medications and meals. 2. NN could smell feces that permeated from the hallway outside the apartment.	L 701		

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L 701	Continued From page 1 3. Upon entering the apartment, NN was overwhelmed with the smell of feces. Piles and piles of random stuff was scattered around the apartment, piled so high and thick, there was a single width path throughout the apartment. 4. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the room. 5. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. 6. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. 7. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined that Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. 8. A 10-13 order was completed, authorizing transport to the hospital. On 10/23/20 NN visited the facility where Resident #1 was receiving care. Resident #1 continued to be paranoid and delusional and was	L 701		

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L 701	Continued From page 2 being treated for pneumonia, chronic obstructive pulmonary disease, diabetes and possible heart problems. A review of facility policies and procedures (P&P) showed the following information: 1. "Services Included in Monthly Residency Fee (Basic Services). Team members will provide supervision in areas of nutrition, medication assistance by certified Team Members and activities of daily living. In addition, the Community will, at its cost, maintain the suite and common areas in good repair. 2. "Additional Services, Housekeeping and Laundry" Housekeeping and laundering of both linens and personal laundry are provided weekly and include basic services. 3. "Resident Assessment and Re-Assessment Process" The Executive Director will have final approval regarding the move-in decision and or continued stay in accordance with regulatory requirements. Frequency of Assessments at least twice a year, at a significant change of condition and re-assessments may be conducted at any time, based on resident status. . 4. Policy "Medication Management Program Guidelines" "Discontinued Medications" Upon receipt of a physician's order to discontinue a medication, the Health and Wellness Director or medication staff will: Transcribe the order on the resident's MAR. Document the information in the resident's wellness file. Notify the pharmacy. A review of the file for Resident #1 showed no documentation that staff had called a physician or	L 701		

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L 701	Continued From page 3	L 701		

pharmacy to see when medications had been discontinued or why. There was no documentation that the facility had contacted the emergency contact listed on the face sheet. There was also no documentation that staff entered the apartment of Resident #1 to assess if there were any fire safety or health hazard issues. There was no admission agreement between Resident #1 and the current governing body.

A review of the "Resident Needs Evaluation and ISP" dated 10/15/20 for Resident #1 showed that this was signed and completed by Staff D. Staff D assessed Resident #1 with the following:

Decision Making Impaired
Shower Assistance Refused
Dressing Independent
Dining Independent
Continence Unsure, will not let anyone in his/her room
Continence Management Refused any type of care
Ambulation Independent
Medication No Medicaiton Orders
Bathing/dressing Independent with bathing

During an interview 11/4/20 Staff D stated Resident #1 had stopped opening the door 3 weeks prior to 11/4/20. Resident #1 had stopped letting housekeeping go into apartment some time ago. Staff D did not know if Resident #1 lost weight because the resident always wore large moo-moo dresses and it was hard to tell his/her shape.

During an interview 11/12/20, Staff D stated he/she completed the assessment for Resident #1 on 10/15/20. Staff D stated he/she had not seen Resident #1 for several days prior to

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L 701	Continued From page 4 10/15/20 and did not see him/her on the day of assessment. Staff D stated spoke to Resident #1 through the closed apartment door. Staff D stated he/she assessed Resident #1 as independent in bathing and dressing. Staff D stated that he/she had seen the resident in the past when he/she had on different clean gowns and was groomed. During an interview 11/12/20, Staff B stated he/she was hired on 10/5/20. Staff B stated he/she did not try to contact Resident #1's emergency contact or physicians listed on the last MAR or history and physical when he/she became aware Resident #1 had barricaded the apartment door, was not accepting facility food and did not take medications. Staff B stated there had not been a nurse in his/her position for awhile so the governing body had sent nurses from other facilities to help out. They were aware of the situation with Resident #1 but it did not appear they had done anything to help the resident.	L 701		
L1132 SS=J	111-8-63-.11(9)(a) Fire Safety. The assisted living community must comply with applicable fire and safety rules published by the Office of the Safety Fire Commissioner. This RULE is not met as evidenced by: ****>>>>Based on record review and interview, the facility failed to comply with applicable fire and safety rules published by the Office of the Safety Fire Commissioner. Findings include: A review of fire evacuation drills conducted between 9/30/19 and 2/14/20 showed drills were	L1132		

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L1132	Continued From page 5 conducted on the following dates and times: 9/30/19 1:48 p.m. 10/13/19 3:00 p.m. 11/29/19 11:15 p.m. 1/14/20 3:05 p .m. 2/14/20 10:30 a.m. There was no indication on the conducted reports of which residents, if any, participated in the fire evacuation drills. During an interview 11/13/20, Staff A stated he/she could not locate any lists of residents who participated in the fire drills and had no knowledge if residents actually did participate.	L1132		
L1300 SS=J	111-8-63-.13(1) Community Safety Precautions. The interior and exterior of the assisted living community must be kept clean, in good repair and maintained free of unsanitary or unsafe conditions which might pose a health or safety risk to the residents and staff. This RULE is not met as evidenced by: ****>>>>Based on observation, record review and interview the facility failed to ensure the interior of the assisted living community was kept clean, in good repair and maintained free of unsanitary or unsafe conditions which might pose a health or safety risk to the residents and staff. During observation on 11/4/20 at 10:30 a.m., the apartment of Resident #1 had terrible odor, even when wearing a mask. Piles of stuffed animals, pillows, and boxes could be seen from the door throughout the apartment. There was a path	L1300		

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L1300	Continued From page 6	L1300		

from the door to the sofa. It did not appear there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window.

A review 11/3/20 of police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident

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L1300	Continued From page 7 #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. During an interview 11/3/20 NN stated he/she was called to the faciity in response to resident having a psychotic event. Upon entering the apartment there was only a path through the apartment. There did not appear to be a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. During an interview on 11/3/20 MM stated he/she and NN pushed their way into Resident #1's apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the ambulance stretcher into the apartment. During an interview 11/2/20 Staff B stated he/she had been employed at the facility about one month. Staff B entered Resident #1's apartment with Staff A and Staff C 10/22/20. They found Resident #1 on the couch. There was feces all over the floor and on Resident #1's feet. The apartment was filled with items to the ceiling.	L1300		

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L1300	Continued From page 8 They could not get through to the bathroom. When asked how he/she got to the bathroom, Resident #1 responded he/she would go on the stuffed animals that were all over the apartment. Staff B stated there was evidence Resident #1 had urinated and defecated on the stuffed animals. During an interview 11/3/20 Staff C stated on 10/22/20 he/she went to Resident #1's room and was let in by the resident. Items were blocking the door which needed to be pushed aside. Staff C had just enough room to slide through the door. There were piles of feces on the floor along with dirty towels that appeared to have been used to clean the floor. Resident #1 was lying on the couch in an awkward position. Resident #1 had feces on his her feet. He/she told Staff C it was pudding that someone had thrown on him/her.	L1300		
L1514 SS=J	111-8-63-.15(6) Change in Condition Requiring Reevaluation. Change in Condition Requiring Reevaluation. In the event a resident develops a significant change in physical or mental condition, the assisted living community must obtain medical information necessary to determine that the resident continues to meet the retention requirements and the assisted living community is capable of meeting the resident's needs. Where the Department has reason to believe either that the assisted living community cannot meet needs of the resident or the resident no longer meets the retention criteria for living in the licensed assisted living community, the governing body must provide to the Department, upon request, a current physical examination for the resident from a physician, advanced practice	L1514		

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L1514	Continued From page 9 registered nurse or physician's assistant as properly authorized. Authority O.C.G.A. §§ 31-2-7,31-2-8 and 31-7-1 et seq. This RULE is not met as evidenced by: ****>>>>Based on record review and interview, the facility failed to ensure in the event a resident develops a significant change in physical or mental condition, the assisted living community must obtain medical information necessary to determine that the resident continues to meet the retention requirements and the assisted living community is capable of meeting the resident's needs for 1 of 1 sampled resident (Resident #1). Findings include: A review of the file for Resident #1 showed Resident Needs Evaluations dated 5/19/20 through 10/15/20 detailing Resident #1 was confused, withdrawn, suspicious, refused to be assessed, would not let anyone in his/her room. There were no medication orders. A review of the Facility Observation Notes dated 9/8/20 through 10/15/20 detailed Resident #1 would not eat any food from the faciity dining room, continued to stay barricaded in his/her room, Resident #1 would talk to staff through the door but not let anyone in. 10/12/20 note Staff B reported he/she attempted to see the resident but the apartment door could only be opened 2 inches. A horrible smell was noted. 10/15/20 note reported there were no changes, Resident #1 continued to deny housekeeping access, there was a strong odor, the staff could only get the apartment door open so far. There was no documentation in the file to show	L1514		

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L1514	Continued From page 10 that staff had attempted to contact the emergency contact listed in the file or any of the physicians listed on the MAR and physician reports. During an interview 11/3/20 MM, social worker with the police task force stated he/she was called in to evaluate if Resident #1 met criteria to be unwillingly sent to the hospital (10-13). MM worked with a mental health agency that had treated Resident #1 in the past for schizophrenia. MM stated when Resident #1 was seen previously at the agency he/she was able to manage while on medications but was not functional without medication. During this visit, Resident #1 had no idea something was wrong. MM stated he/she and NN pushed their way into the apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the stretcher into the apartment. During an interview 11/12/20 Staff A stated he/she became aware of the situation with Resident #1 the end of 9/2020 or the beginning of 10/2020. Staff A stated he/she did not contact any physician, medical facility or the emergency contact regarding caring for Resident #1. During interview 11/12/20 Staff B stated he/she did not contact any physicians listed on Resident #1's MAR or physician reports. Staff B stated	L1514		

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L1514	Continued From page 11 he/she did not know when Resident #1 last took medications, the last MAR he/she could locate was dated 5/2016. .	L1514		
L1612 SS=J	111-8-63-.16(3) Admission Agreements. The assisted living community must provide the resident and representative or legal surrogate, if any, with a signed copy of the agreement. A copy signed by both parties (resident and administrator or on-site manager) must be retained in the resident's file and maintained by the administrator or on-site manager of the assisted living community. This RULE is not met as evidenced by: ****>>>>Based on record review and interview, the facility failed to provide the resident and representative or legal surrogate, if any, with a signed copy of the agreement. A copy signed by both parties (resident and administrator or on-site manager) must be retained in the resident's file and maintained by the administrator or on-site manager of the assisted living community for 1 of 1 sampled resident (Resident #1). Findings include: A review of Department records showed the facility was granted a permit to operate 6/18/19. A review of the file for Resident #1 showed admission date of 10/19/15. There was no admission agreement between the resident and the current governing body. During an interview 11/9/20, Staff A stated there	L1612		

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L1612	Continued From page 12 was no signed admission agreement between Resident #1 and the facility or governing body.	L1612		
L1709 SS=J	111-8-63-.17(3)(g) Written Care Plan. The care plan must include the following: ... (g) evidence of the care plan being updated at least annually and more frequently where the needs of the resident change substantially or the resident is assigned to a specialized memory care unit. This RULE is not met as evidenced by: ****>>>>Based on record review and interview, the facility failed to provide evidence of the care plan being updated at least annually and more frequently where the needs of the resident changed substantially for 1 of 1 sampled resident (Resident #1). Findings include: A review on 11/3/20 of the file for Resident 1 showed a 10/15/20 "Resident Needs Evaluation and ISP" completed by Staff D. In this evaluation Staff D indicated Resident #1 was independent in bathing, dressing, grooming and dining. Under Continence Staff D indicated he/she was unsure as Resident #1 would not let anyone into the room. Staff D noted under Medication there were no medication orders. Review 11/3/20 of police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was	L1709		

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L1709	Continued From page 13 overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. On 10/23/20 NN visited the hospital where Resident #1 was receiving care. Resident #1 continued to be paranoid and delusional and was being treated for pneumonia, chronic obstructive pulmonary disease, diabetes and possible heart problems. During an interview 11/12/20 Staff D , LPN, stated he/she did not see Resident #1 on 10/15/20 when the evaluation was completed. Staff D stated he/she completed the evaluation based on what he/she saw on previous occasions when	L1709		

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L1709	Continued From page 14 Resident #1 would open the door. During the 10/15/20 evaluation Staff D spoke to Resident #1 through a closed door. During an interview 11/4/20 Staff D stated he/she had worked at the facility 4 years. Staff D had last seen Resident #1 approximately 1 week prior to day the resident taken to hospital. Staff D stated he/she would go by the apartment daily and could hear Resident #1 talking to him/herself in the apartment. Staff D stated in his/her 4 years at the facilty, Resident #1 had never taken medications. There was never an MAR. Staff D did not know of any doctor visits in the past 4 years. When he/she started working 4 years ago, Resident #1 would come out into the hall to talk to him/her. In the past 3 weeks Resident #1 refused to open the door. In the past month or month and half Resident #1 stopped eating facility food. From the beginning Resident #1 talked about the military spying on him/her. During an interview 11/4/20 Staff F stated he/she had worked at the facility 1 year and 2 months. Staff F was a CNA and CMA. Staff F knocked on the door several times with no response. Staff F would deliver meals and leave the tray on the shelf by the door. Resident #1 eventually took the tray if he/she wanted to eat it. When Staff F began working at the facility, Resident #1 would come out to play the piano or go grocery shopping. Because Resident #1 blocked the door, Staff F could not really open the door. Sometimes the resident would open the door and peek out. When Staff F could see Resident #1, he/she was unkempt, wearing a dirty nightgown, had greasy hair and had body odor. Staff F stated the last time he/she could remember Resident #1 coming out of the apartment was a couple of months ago.	L1709		

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L1709	Continued From page 15 During an interview 11/4/20 Staff E stated he/she had worked at the facility over 20 years. Staff E last saw Resident #1 one week prior. The resident's hair was not clean, dress was stained and dirty. Staff E did not look at the resident's feet. When Resident #1 moved in in 2015 Staff E helped him/her bathe and dress. Then the resident began to say the government had told him/her not to get in the water. Staff E stated Resident #1 started to barricade his/her door a few years ago.	L1709		
L2311 SS=J	111-8-63-.23(9) Infection Control, Sanitation and Supplies. The assisted living community must clean the residents' private living spaces periodically and as needed to ensure that the space does not pose a health hazard. Authority O.C.G.A. §§ 31-2-7, 31-2-8 and 31-7-1 et seq. This RULE is not met as evidenced by: ****>>>>Based on observation and interview, the facility failed to clean the residents' private living spaces periodically and as needed to ensure that the space does not pose a health hazard for 1 of 1 sampled resident (Resident #1). During observation on 11/4/20 at 10:30 a.m.,the odor in Resident #1's apartment was terrible, even when wearing a mask. Piles of stuffed animals, pillows, boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of	L2311		

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L2311	Continued From page 16 food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window. A review on 11/3/20 of police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and was covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was	L2311		

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L2311	Continued From page 17 completed, authorizing transport to the hospital. During an interview 11/3/20 NN stated he/she was called to the faciity in response to resident having a psychotic event. Upon entering the apartment there was only a path through the apartment. There did not appear to be a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. During an interview 11/3/20 MM stated he/she and NN pushed their way into Resident #1's apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the ambulance stretcher into the apartment. During an interview 11/2/20 Staff B stated he/she had been employed at the facility about one month. Staff B entered Resident #1's apartment with Staff A and Staff C 10/22/20. They found Resident #1 on the couch. There was feces all over the floor and on Resident #1's feet. The apartment was filled with items to the ceiling. They could not get through to the bathroom. When asked how he/she got to the bathroom, Resident #1 responded he/she would go on the stuffed animals that were all over the apartment.	L2311		

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L2311	Continued From page 18 Staff B stated there was evidence Resident #1 had urinated and defecated on the stuffed animals. During an interview 11/3/20 Staff C stated on 10/22/20 he/she went to Resident #1's room and was let in by the resident. Items were blocking the door which needed to be pushed aside. Staff C had just enough room to slide through the door. There were piles of feces on the floor along with dirty towels that appeared to have been used to clean the floor. Resident #1 was lying on the couch in an awkward position. Resident #1 had feces on his her feet. He/she told Staff C it was pudding that someone had thrown on him/her.	L2311		
L2501 SS=K	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 that each resident received care and services which were adequate, appropriate, and in compliance with state law and regulations for 1 of 1 sampled resident (Resident #1). Findings include: A review of the incident report submitted to the Department dated 10/26/26, showed Resident #1 was having a mental crisis, was unable to care for himself/herself, and needed medical attention. Resident #1 was transferred to the emergency room for evaluation and treatment.	L2501		

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L2501	Continued From page 19 During an interview 11/3/20 NN stated he/she was called to the faciity in response to resident having a psychotic event. Upon entering the apartment there was only a path through the apartment. There did not appear to be a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. NN stated there apparently was new management at the facility. They discovered Resident #1 had not paid rent for many, many months, signifying a problem with the resident. NN stated it was apparent Resident #1 had a situation going on for some time, his/her decline did not happen overnight. NN did not understand why staff from the facility did not intervene earlier. A review of the file for Resident #1, admitted on 10/19/15 showed diagnoses of psychotic with delusions. The medications prescribed on admission were the following: Novolog 5 units three times daily before meals Lantus 15 unites at nightly Carvedilol (Coreg) 6.25 mg twice daily for hypertension Donepezil (Aricept) 5 mg at night for dementia Levothyroxine (Levothyroid) 125 mg nightly for hypothyroidism Lisinopril (Prinivl) 10 mg daily for high blood pressure Albuterol 90 (Proventil) 1 puff every 6 hours as needed for asthma or chronic obstructive pulmonary disease A 5/2016 facility Medication Administration Record (MAR) showed all of the above medications were continued plus the following	L2501		

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L2501	Continued From page 20 were added: Metformin 500 mg twice daily for diabetes Atorvastatin 20 mg once daily for high cholesterol Furosemide (Lasix) 40 mg once daily for fluid retention Glipizide 5 mg twice daily for diabetes There was no MAR in the file after 5/2016. A review of Resident Needs Evaluations showed the following: 10/15/20 Resident refused any type of care. Continence was unknown, resident would not let anyone into his/her room. There were no medication orders. 10/2/20 Resident was evaluated as confused, withdrawn, easily upset, suspicious, interferes with care. 9/22/20 Resident refused to be assessed. 8/21/20 Resident refused to be assessed. 7/3120 Resident refused to be assessed 6/20/20 Resident was non compliant 5/19/20 Resident was assessed as non compliant with psychotic delusions, no medications A review of the facility Observation Notes showed the following: 9/8/20 Resident not eating food from dining room. Stated the army has sprayed the food with poison, has snacks in room 9/22/20 Continues to stay barricaded in his/her room. Will talk to staff through his/her door. Continues to say he/she has food in his/her room. Not accepting food from facility 10/12/20 Staff B noted he/she heard no one was able to see Resident #1 and the resident barricaded the door to his/her room. Attempted to see the resident but could only open the door 2	L2501		

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L2501	Continued From page 21	L2501		

inches. Resident #1 stated he/she did not need anything. Horrible smell was noted 10/15/20 No changes with resident. Staff was able to see resident through open door. Door would only open a bit so far. Will not let housekeeping come in to clean. Room very odorous. Continues to refuse meals from dining room.

A review on 11/3/20 of police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff were scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpet was dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but

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L2501	Continued From page 22 was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. On 10/23/20 NN visited the hospital where Resident #1 was receiving care. Resident #1 continued to be paranoid and delusional and was being treated for pneumonia, chronic obstructive pulmonary disease, diabetes and possible heart problems. During observation on 11/4/20 at 10:30 a.m., the odor in apartment of Resident #1 was so unbearable that the smell permeated even through a mask. Piles at least 4 feet high of stuffed animals, pillows, boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window. During an interview 11/2/20 Staff A stated he/she just recently started working at the facility. Staff A stated Resident #1 had been living in assisted living since 2015. When Staff A started working he/she was told Resident #1 would not let anyone into the apartment. The resident did not take any medications. Meals were left on trays for him/her, in the hallway outside his/her apartment door. Resident #1 did not eat the food the facility provided, telling staff the government had poisoned it. A friend would come monthly and take Resdent #1 out to shop for groceries. Staff	L2501		

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L2501	Continued From page 23 A stated he/she tried to see Resident #1 but could only open the apartment door 2 inches, it was blocked. Staff A could talk to Resident #1 but not see him/her. Staff C, who is Staff A's supervisor, visited and was able to coax Resident #1 into opening the door enough to get in. During an interview 11/12/20 Staff A stated he/she was hired 8/24/20. He/she became aware of Resident #1's situation around the end of 9/2020 or beginning of 10/2020. Staff A stated he/she did not attempt to contact Resident #1's emergency contact or any of the physician's listed on the resident's MAR and History and Physical. During an interview 11/2/20 Staff B stated he/she had been employed at the facility about one month. Staff B entered Resident #1's apartment with Staff A and Staff C 10/22/20. They found Resident #1 on the couch. There was feces all over the floor and on Resident #1's feet. The apartment was filled with items to the ceiling. They could not get through to the bathroom. When asked how he/she got to the bathroom, Resident #1 responded he/she would go on the stuffed animals that were all over the apartment. Staff B stated there was evidence Resident #1 had urinated and defecated on the stuffed animals. The smell was horrendous. Resident #1 refused medical care. Staff A called 911 and police responded with a behavior health team. They were able to find Resident #1 incompetent and they sent the resident to the hospital. The contact person listed in the records was a former coworker who had not spoken to Resident #1 in over a year. That person gave Staff A and Staff B the contact information for a sibling of Resident #1 who lived in St. Simons GA. The sibling told them he/she had not spoken to Resident #1 in many years.	L2501		

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L2501	Continued From page 24 During an interview 11/3/20 Staff B, R.N, stated there was no current MAR for Resident #1 because the resident did not take any medications. Staff B stated he/she did not know when the resident last took medications. During an interview 11/4/20 Staff B stated he/she could not find any records of doctor visits since 2015 and no records of medications after 5/2016. During an interview 11/12/20 Staff B stated his/her hire date was 10/5/20. Staff B stated he/she did not try to contact Resident #1's emergency contact or physicians listed on the last MAR or history and physical when he/she became aware Resident #1 had barricaded the apartment door, was not accepting facility food and did not take medications. Staff B stated there had not been a nurse in his/her position for awhile so the governing body had sent nurses from other facilities to help out. They were aware of the situation with Resident #1 but it did not appear they had done anything to help the resident. During an interview 11/3/20 Staff C stated he/she worked in the corporate office but was at this facility several times over the past few weeks. Staff C stated the week prior to 10/22/20 he/she had gone to Resident #1's apartment. Resident #1 opened the door a few inches and spoke to Staff C. He/she could see into the apartment. There was no feces on the floor or on Resident #1. There was no odor of urine or feces. On 10/22/20 Staff C again went to Resident #1's and was let in by the resident. Items were blocking the door which needed to be pushed aside. Staff C had just enough room to slide through the door. There were piles of feces on the floor along with	L2501		

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L2501	Continued From page 25	L2501		

dirty towels that appeared to have been used to clean the floor. Resident #1 was lying on the couch in an awkward position. Resident #1 had feces on his her feet. He/she told Staff C it was pudding that someone had thrown on him/her. Resident #1 talked about organized crime and snipers trying to kill anyone who came to help him/her. He/she refused when asked if EMS could be called. Staff A called 911 and EMS arrived. When they arrived they did a mini mental evaluation, took blood pressure and temperature. Resident #1 was able to correctly tell them the day, year and who was president. They could not force the resident to go to the hospital. EMT called police task force that specialized in helping the mentally ill. A social worker, a police officer and a negotiator came. Resident #1 gave wild answers and they decided to send Resident #1 to the hospital for a mental health evaluation, against his/her will.
Staff C stated the apartment was packed full of stuff with just pathways to get around.

During an interview 11/3/20 MM stated he/she was a social worker with the police task force and was called in to evaluate if Resident #1 met criteria to be unwillingly sent to the hospital (10-13). MM worked with a mental health agency that had treated Resident #1 in the past for schizophrenia. MM stated when Resident #1 was seen previously at the agency he/she was able to manage while on medications but was not functional without medication. During this visit, Resident #1 had no idea something was wrong. MM stated he/she and NN pushed their way into the apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the

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L2501	Continued From page 26	L2501		

way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on Resident #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the stretcher into the apartment.

During an interview 11/4/20 Staff D, LPN, stated he/she had worked at the facility 4 years. Staff D had last seen Resident #1 approximately 1 week prior to day the resident taken to hospital. Staff D stated he/she would go by the apartment daily and could hear Resident #1 talking to him/herself in the apartment. Staff D stated in his/her 4 years at the facilty, Resident #1 had never taken medications. There was never an MAR. Staff D did not know of any doctor visits in the past 4 years. When he/she started working 4 years ago, Resident #1 would come out into the hall to talk to him/her. In the past 3 weeks Resident #1 refused to open the door. In the past month or month and half Resident #1 stopped eating facility food. From the beginning Resident #1 talked about the military spying on him/her.

During an interview 11/4/20 Staff F stated he/she had worked at the facility 1 year and 2 months. Staff F was a CNA and CMA. Staff F had knocked on Resident # 1's door several times with no response. Staff F would deliver meals and leave the tray on the shelf by the door. Resident #1 eventually took the tray if he/she wanted to eat it. When Staff F began working at the facility, Resident #1 would come out to play the piano or go grocery shopping. Because Resident #1 blocked the door, Staff F could not really open the door. Sometimes the resident would open the door and peek out. When Staff F could see Resident #1, he/she was unkempt,

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L2501	Continued From page 27 wearing a dirty nightgown, had greasy hair and had body odor. Staff F stated the last time he/she could remember Resident #1 coming out of the apartment was a couple of months ago. During an interview 11/4/20 Staff E stated he/she had worked at the facility over 20 years. Staff E last saw Resident #1 one week prior. The resident's hair was not clean, and clothing was stained and dirty. Staff E did not look at the resident's feet. When Resident #1 moved in in 2015 Staff E helped him/her bathe and dress, then the resident began to say the government had told him/her not to get in the water. Staff E stated Resident #1 started to barricade his/her door a few years ago. During an interview OO, previous administrator, stated Resident #1 could not keep a doctor, they would refuse to treat him/her after awhile. OO stated he/she tried to get a psychiatrist to see Resident #1 at the facility. OO called the crisis team. The crisis team told him/her that the resident knew the date, time, year, location, name, current president. They said they could not take the resident to the hospital against his/her will, he/she had the right to refuse treatment and medications. OO stated he/she did not know the last time Resident #1 saw a doctor or took medications. OO stated they tried their best to get help for Resident #1. OO stated he/she called other crisis team professional agencies and no one would help. During an interview 11/5/20 PP, previous DON, stated he/she last worked at the facility mid 2018. PP stated it had been years since Resident #1 took medications or saw a doctor. Staff would make doctor appointments and Resident #1 would refuse to go. Resident #1 had medications	L2501		

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L2501	Continued From page 28 and orders when he/she moved in but when those orders ran out Resident #1 did not have orders for refills and would not see a doctor for renewed prescriptions, so 2016 was probably the last time the resident took medications. PP stated they had called the crisis team to come evaluate Resident #1. They said Resident #1 was alert and oriented and they would not take him/her to the hospital. PP stated he/she had called EMS many times but they refused to transport the resident but he/she refused treatment. There was no documentation in the file of Resident #1 to show when or how often staff checked on Resident #1 or tried to encourage the resident to accept help. There was no documentation that staff verified Resident #1 had food available in the apartment on the days the resident refused facility food. There was no documentation the facility had reported to Adult Protective Services to get help for Resident #1. There was no documentation the facility tried to contact Resident #1's emergency contact prior to 10/22/20. There was no documentation the facility attempted to enter the apartment prior to 10/22/20 to assess if a fire hazard or health hazard existed. This violation was previously cited 10/2/20.	L2501		
L2512 SS=J	111-8-63-.25(1)(i) Supporting Residents' Rights. Each resident must have the right to be free from mental, verbal, sexual and physical abuse, neglect and exploitation. This RULE is not met as evidenced by:	L2512		

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L2512	Continued From page 29 ****>>>>Based on observation, record review and interview, the facility failed to ensure each resident had the right to be from neglect for 1 of 3 sampled resident (Resident #1). Findings include: During an interview 11/3/20 NN stated he/she was called to the faciity in response to resident having a psychotic event. NN stated when he/she entered the apartment there was only a path through the apartment, including a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. NN stated there apparently was new management at the facility. They discovered Resident #1 had not paid rent for many, many months, signifying a problem with the resident. NN stated it was apparent Resident #1 had a situation going on for some time, his/her decline did not happen overnight. NN did not understand why staff from the facility did not intervene earlier. A review of the file for Resident #1, admitted on 10/19/15 showed diagnoses of psychotic delusions. The following medications were prescribed on admission: Novolog 5 units three times daily before meals Lantus 15 unites at nightly Carvedilol (Coreg) 6.25 mg twice daily for hypertension Donepezil (Aricept) 5 mg at night for dementia Levothyroxine (Levothyroid) 125 mg nightly for hypothyroidism Lisinopril (Prinivl) 10 mg daily for high blood pressure	L2512		

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L2512	Continued From page 30 Albuterol 90 (Proventil) 1 puff every 6 hours as needed for asthma or chronic obstructive pulmonary disease A 5/2016 facility Medication Administration Record (MAR) showed all of the above medications were continued plus the following were added: Metformin 500 mg twice daily for diabetes Atorvastatin 20 mg once daily for high cholesterol Furosemide (Lasix) 40 mg once daily for fluid retention Glipizide 5 mg twice daily for diabetes There was no MAR in the file after 5/2016. A review of Resident Needs Evaluations showed the following information: : 10/15/20 Resident refused any type of care. Continence was unknown, resident would not let anyone into his/her room. There were no medication orders. 10/2/20 Resident was evaluated as confused, withdrawn, easily upset, suspicious, interferes with care. 9/22/20 Resident refused to be assessed. 8/21/20 Resident refused to be assessed. 7/3120 Resident refused to be assessed 6/20/20 Resident was non compliant 5/19/20 Resident was assessed as non compliant with psychotic delusions, no medications A review of the Facility Observation Notes showed the following: 9/8/20 Resident not eating food from dining room. Stated the army has sprayed the food with poison, has snacks in room 9/22/20 Continues to stay barricaded in his/her room. Will talk to staff through his/her door. Continues to say he/she has food in his/her room.	L2512		

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L2512	Continued From page 31 Not accepting food from facility 10/12/20 Staff B noted he/she heard no one was able to see Resident #1 and the resident barricaded the door to his/her room. Attempted to see the resident but could only open the door 2 inches. Resident #1 stated he/she did not need anything. Horrible smell was noted 10/15/20 No changes with resident. Staff was able to see resident through open door. Door would only open a bit so far. Will not let housekeeping come in to clean. Room very odorous. Continues to refuse meals from dining room. A review of faciity documentation showed no documentation of when or how often staff checked on Resident #1 or tried to encourage the resident to accept help. There was no documentation that staff verified Resident #1 had food available in the apartment on the days the resident refused facility food. There was no documentation the facility had reported to Adult Protective Services to get help for Resident #1. There was no documentation of any intervention by the facility, besides calling 911 on 10/22/20. There was no documentation the facility tried to contact Resident #1's emergency contact prior to 10/22/20. There was no documentation the facility attempted to enter the apartment prior to 10/22/20 to assess if a fire hazard existed. A review on 11/3/20 of the police report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and was covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and	L2512		

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L2512	Continued From page 32 piles of random stuff were scattered around the apartment, piled so high and thick there was a single path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital. On 10/23/20 NN visited the hospital where Resident #1 was receiving care. Resident #1 continued to be paranoid and delusional and being treated for pneumonia, chronic obstructive pulmonary disease, diabetes and possible heart problems. A review 11/10/20 of 10/22/20 ambulance report showed emergency personnel arrived at the facility 10/22/20 at 1:38 p.m. reported to EMTs Resident #1 was refusing medications, food, drink, showers and having laundry done. Staff reported Resident #1 was having hallucinations. The EMTs found Resident #1 in his/her	L2512		

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L2512	Continued From page 33	L2512		

apartment. The resident had feces on him/her, on the floor, furniture and stuffed animals. Resident #1 was oriented to to date, time and place but was having delusions and hallucinations of snipers. Resident #1 reported he/she had no medical problems, no pain. A mental health evaluation was done by other specialists called to the scene. Resident #1 was determined to be a hazard to self. When EMS staff tried to put Resident #1 in the ambulance he/she became combative and EMS staff administered 2 mg of Ativan. After 5 minutes Resident #1 voluntarily allowed EMS staff to place him/her in the ambulance. Resident #1 was transported to Memorial University Health Hospital at 4:33 p.m.

During observation on 11/4/20 at 10:30 a.m., the odor in Resident #1's apartment was terrible, even with a mask on. Piles of stuffed animals, pillows, boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear that there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window.

During an interview on 11/2/20 Staff A stated he/she just recently started working at the facility. Staff A stated Resident #1 had been living in assisted living since 2015. When Staff A started working he/she was told Resident #1 would not let anyone into the apartment. The resident did not take any medications. Meals were left on

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L2512	Continued From page 34 trays for him/her, in the hallway outside his/her apartment door. Resident #1 did not eat the food the facility provided, telling staff the government had poisoned it. A friend would come monthly and take Resdent #1 out to shop for groceries. Staff A stated he/she tried to see Resident #1 but could only open the apartment door 2 inches, it was blocked. Staff A could talk to Resident #1 but not see him/her. Staff C, who is Staff A's supervisor, visited and was able to coax Resident #1 into opening the door enough to get in. During an interview on 11/2/20, Staff B stated he/she had been employed at the facility about one month. Staff B entered Resident #1's apartment with Staff A and Staff C 10/22/20, they found Resident #1 on the couch. There was feces all over the floor and on Resident #1's feet. The apartment was filled with items to the ceiling. They could not get through to the bathroom. When asked how he/she got to the bathroom, Resident #1 responded he/she would go on the stuffed animals that were all over the apartment. Staff B stated there was evidence Resident #1 had urinated and defecated on the stuffed animals. The smell was horrendous. Resident #1 refused medical care. Staff A called 911 and police responded with a behavior health team. They were able to find Resident #1 incompetent and they sent the resident to the hospital. Staff B stated he/she had been told Resident #1's only child was deceased in 2016. The contact person listed in the records was a former coworker who had not spoken to Resident #1 in over a year. That person gave Staff A and Staff B the contact information for a sibling of Resident #1 who lived in another town. The sibling told them he/she had not spoken to Resident #1 in many years. During an interview 11/3/20 Staff B, stated there	L2512		

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L2512	Continued From page 35 was no current MAR for Resident #1 because the resident did not take any medications. Staff B stated he/she did not know when the resident last took medications. During an interview 11/4/20 Staff B stated he/she could not find any records of doctor visits since 2015 and no records of medications after 5/2016. During an interview 11/12/20 Staff B stated his/her hire date was 10/5/20. Staff B stated he/she did not try to contact Resident #1's emergency contact or physicians listed on the last MAR or history and physical when he/she became aware Resident #1 had barricaded the apartment door, was not accepting facility food and did not take medications. Staff B stated there had not been a nurse in his/her position for awhile so the governing body had sent nurses from other facilities to help out. They were aware of the situation with Resident #1 but it did not appear they had done anything to help the resident. During an interview 11/3/20 Staff C stated he/she worked in the corporate office but was at this facility several times over the past few weeks. Staff C stated the week prior to 10/22/20 he/she had gone to Resident #1's apartment. Resident #1 opened the door a few inches and spoke to Staff C. He/she could see into the apartment. There was no feces on the floor or on Resident #1. There was no odor of urine or feces. On 10/22/20 Staff C again went to Resident #1's and was let in by the resident. Items were blocking the door which needed to be pushed aside. Staff C had just enough room to slide through the door. There were piles of feces on the floor along with dirty towels that appeared to have been used to clean the floor. Resident #1 was lying on the	L2512		

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L2512	Continued From page 36	L2512		

couch in an awkward position. Resident #1 had feces on his her feet. He/she told Staff C it was pudding that someone had thrown on him/her. Resident #1 talked about organized crime and snipers trying to kill anyone who came to help him/her. He/she refused when asked if EMS could be called. Staff A called 911 and EMS arrived. When they arrived they did a mini mental evaluation, took blood pressure and temperature. Resident #1 was able to correctly tell them the day, year and who was president. They could not force the resident to go to the hospital. EMT called police task force that specialized in helping the mentally ill. A social worker, a police officer and a negotiator came. Resident #1 gave wild answers and they decided to send Resident #1 to the hospital for a mental health evaluation, against his/her will. Staff C stated the apartment was packed full of stuff with just pathways to get around.

During an interview 11/3/20 MM stated he/she was called 10/22/20 to evaluate if Resident #1 met criteria to be unwillingly sent to the hospital (10-13). MM stated Resident #1 was seen several years before at a mental health agency that had treated Resident #1 for schizophrenia. MM stated when Resident #1 was seen previously at the agency he/she was able to manage while on medications but was not functional without medication. MM stated he/she and NN pushed their way into the apartment. There was barely enough room for 3 people to stand because the apartment was full of furniture and other personal items. There was a path from the front door to the couch. There was no path to get to the bathroom, the way was blocked with furniture. Near the couch there was a bucket of feces, a pile of feces on the floor, feces and urine on stuffed animals, on the couch and on Resident

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L2512	Continued From page 37 #1. The smell was horrendous. Items had to be moved out of the apartment and into the hall to get the stretcher into the apartment. During an interview 11/4/20 Staff D, LPN, stated he/she had worked at the facility 4 years. Staff D had last seen Resident #1 approximately 1 week prior to day the resident taken to hospital. Staff D stated he/she would go by the apartment daily and could hear Resident #1 talking to him/herself in the apartment. Staff D stated in his/her 4 years at the facilty, Resident #1 had never taken medications. There was never an MAR. Staff D did not know of any doctor visits in the past 4 years. When he/she started working 4 years ago, Resident #1 would come out into the hall to talk to him/her. In the past 3 weeks Resident #1 refused to open the door. In the past month or month and half Resident #1 stopped eating facility food. From the beginning Resident #1 talked about the military spying on him/her. During an interview 11/4/20 Staff F stated he/she had worked at the facility 1 year and 2 months. Staff F was a CNA and CMA. Staff F knocked on the door several times with no response. Staff F would deliver meals and leave the tray on the shelf by the door. Resident #1 eventually took the tray if he/she wanted to eat it. When Staff F began working at the facility, Resident #1 would come out to play the piano or go grocery shopping. Because Resident #1 blocked the door, Staff F could not really open the door. Sometimes the resident would open the door and peek out. When Staff F could see Resident #1, he/she was unkempt, wearing a dirty nightgown, had greasy hair and had body odor. Staff F stated the last time he/she could remember Resident #1 coming out of the apartment was a couple of months ago.	L2512		

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L2512	Continued From page 38 During an interview 11/4/20 Staff E stated he/she had worked at the facility over 20 years. Staff E last saw Resident #1 one week prior to 10/22/20. The resident's hair was not clean, dress was stained and dirty. Staff E did not look at the resident's feet. When Resident #1 moved into the facility in 2015 Staff E helped him/her bathe and dress. Then the resident began to say the government had told him/her not to get in the water. Staff E stated Resident #1 started to barricade his/her door a few years ago.	L2512		
L2600 SS=J	111-8-63-.26(1) Procedures for Change in Resident's Condition In case of an accident or sudden adverse change in a resident's condition or adjustment, an assisted living community must immediately take the actions appropriate to the specific circumstances to address the needs of the resident, including notifying the representative or legal surrogate, if any. The assisted living community must retain a record of all such adverse changes and the assisted living community's response in the resident's files. This RULE is not met as evidenced by: ****>>>>Based on record review and interview, the facility failed to ensure that in case of an accident or sudden adverse change in a resident's condition or adjustment, immediate actions appropriate to the specific circumstances were taken to address the needs of the resident, including notifying the representative or legal surrogate, if any. The assisted living community must retain a record of all such adverse changes and the assisted living community's response in	L2600		

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L2600	Continued From page 39	L2600		

the resident's files for 1 of 1 sampled resident (Resident #1). Findings include:

A review on 11/3/20 of the LE report showed NN arrived at the facility 10/22/20 at 2:21 p.m. in response to a call that a resident was suffering from psychosis and covered in feces. Staff A reported to NN that Resident #1 was refusing medications and meals. NN reported he/she could smell feces from the hallway outside the apartment. Upon entering the apartment NN was overwhelmed with the smell of feces. Piles and piles of random stuff was scattered around the apartment, piled so high and thick there was a single width path throughout the apartment. The carpets were dirty, sink was overflowing and there were dead flies/bugs all over the home. There was feces on the floor near the couch and on Resident #1's feet and ankles. NN was not only concerned about Resident #1's health and wellbeing medically but also about safety based on inaccessibility to the apartment by medical and fire personnel. In interview, Resident #1 told NN the doctor was involved with the mafia and spoke incoherently about people involved in the mafia, there were 30 crime syndicates. Resident #1 was paranoid about criminal groups having video and sound recordings devices listening to him/her. NN asked Resident #1 about the feces on his/her feet. Resident #1 responded it was cookie dough and became very upset, yelling that military doctors would come take him/her away. Members of the task force determined Resident #1 was not only unable to care for him/herself but was in danger of suffering serious illness if not properly medically evaluated by medical and psychiatric doctors. A 10-13 order was completed, authorizing transport to the hospital.

A review of the file for Resident #1 provided no

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SAVANNAH COMMONS	1 PEACHTREE DRIVE SAVANNAH, GA 31419

(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
L2600	Continued From page 40 documentation to show that any staff attempted to contact the emergency contact listed on the resident's face sheet. There was no documentation to show that staff attempted to call the physician listed on the admitting history and physical and the last MAR. Observation note dated 9/8/20 showed Resident #1 was not eating food provided by the facility, there were snacks in the resident's room. 9/22/20 note showed Resident #1 continued to barricade him/herself in the room. Not accepting any food from the facility. 10/12/20 note by Staff B showed he/she and Staff F attempted to see Resident #1. They were able to push the door open only two inches. They could not see the resident. A horrible smell was noted. During an interview on 11/12/20 Staff B stated his/her hire date was 10/5/20. Staff B stated he/she did not try to contact Resident #1's emergency contact or physicians listed on the last MAR or history and physical when he/she became aware Resident #1 had barricaded the apartment door, was not accepting facility food and did not take medications. Staff B stated there had not been a nurse in his/her position for awhile so the governing body had sent nurses from other facilities to help out. They were aware of the situation with Resident #1 but it did not appear they had done anything to help the resident.	L2600		
L2800 SS=J	111-8-63-.28(1) Immediate Transfers of Residents. The administrator or on-site manager of the assisted living community must initiate an immediate transfer to an appropriate setting if the resident develops a physical or mental condition	L2800		

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L2800	Continued From page 41 requiring continuous medical care or nursing care. This RULE is not met as evidenced by: ****>>>>Based on observation, record review and interview, the facility failed to ensure the administrator or on-site manager of the assisted living community initiated an immediate transfer to an appropriate setting if the resident developed a physical or mental condition requiring continuous medical care or nursing care for 1 of 1 sampled resident (Resident #1). Findings include: A review of the file for Resident #1 showed observation notes (ONs) dated 9/8/20 for Resident #1. The ONs showed that Resident #1 was not eating food provided by the facility. On 9/22/20, Resident #1 continued to barricade him/herself in the room. The resident was not accepting any food from the facility. On 10/12/20, Staff B and Staff F attempted to see Resident #1. They were able to push the door open only two inches, and they could not see the resident. A horrible smell was noted. Further review of the file provided no documentation to show that staff attempted to contact the emergency contact listed on the resident's face sheet. There was also no documentation that staff attempted to call the physician listed on the admitting history and physical and on the last MAR. During an interview 11/3/20, NN stated he/she was called to the facility in response to resident having a psychotic event. Upon entering the apartment there was only a path through the apartment. There did not appear to be a path to the bathroom. Windows were blocked. Living room windows blocked by blankets and bedroom	L2800		

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L2800	Continued From page 42 windows blocked by stacks of styrofoam coolers. Feces was on the floor near the couch, on the couch and on Resident #1. Resident #1 was unable to have a coherent conversation. NN stated there apparently was new management at the facility. They discovered Resident #1 had not paid rent for many, many months, signifying a problem with the resident. NN stated it was apparent Resident #1 had a situation going on for some time, his/her decline did not happen overnight. NN did not understand why staff from the facility did not intervene earlier. During observation on 11/4/20 at 10:30 a.m., the odor in Resident #1's apartment was terrible, even when wearing a mask. Piles of stuffed animals, pillows, boxes could be seen from the door throughout the apartment. There was a path from the door to the sofa. It did not appear there was a path from the living room to the bedroom and bathroom. There were dark stains on the carpet and sofa. There were no visible signs of food or medications in the room. The living room window was covered with blankets. The bedroom window was blocked with something, but from the living room it was difficult to see what was used to block access to the window.	L2800		

the Social
BY THRIVE
SAVANNAH

October 2, 2020

In response to a recent survey, the following is a plan of correction. Please note: the official, written report has not yet been received, and the information below is based on a verbal report from Rachel Barevich, BSW from the State of Georgia, Department of Community Health.

-The current Thrive Senior Living lease agreement states that an emergency call system is in place. However, the Arbors Memory Care, at the Social at Savannah, does not have a functioning call system. The citation was for not following our own policy. The lease agreement will be revised, and that language will be removed from the lease, as well as the move in checklist. In addition, the pull cords that were visually present in the Arbors have been removed to prevent assumptions with prospects.

-A care and services tag was also given for the resident's care needs not being met due to the care plans having been locked in the med room. The care plans are now kept in a readily accessible area so that caregivers can access them and assure care plans are being followed.

Jennifer Mohler | Community President
The Social at Savannah

State of GA, Healthcare Facility Regulation Division

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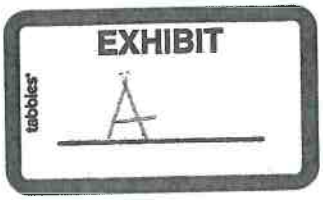
L 000	Initial Comments. >>>>The purpose of this visit on was to investigate intake #GA00208098. The investigation started on 9/18/20 and was completed 10/2/20.	L 000		
L 701 SS=J	111-8-63-.07(2) Owner Governance. The governing body is responsible for implementing policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to implement their policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. Findings include: A review of the admission agreement (AA) for Resident #1 showed that an emergency call device in bedroom/bathroom area would be provided. A review of the Resident Suite Inspection Checklist on 9/5/20 for Resident #1 showed an E Call System was ready in his/her suite. During an interview on 9/13/20, GG stated on the first night of Resident #1 at the facility, he/she fell and fractured his/her hip. The call bell system at this facility was not working. GG stated he/she was unaware the call bell system was not working and would not have left Resident #1	L 701		

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L 701	Continued From page 1 there if he/she had known. During an interview on 9/21/20 , GG stated the facility staff told him/her there was a call bell system in the memory care unit (MCU). GG stated the call bell system was also included in the AA. During an interview on 9/21/20, Staff A stated there was no working call bell system in the MCU and there never has been. Staff A stated there were pull cords in the rooms, but they were not hooked to a system. Staff A stated they never told families there was a call bell system in the MCU. During an interview on 9/24/20, Staff A stated staff were to do checks every 2 hours on residents. Staff A stated that after Resident #1 fell and fractured his/her hip, a policy was implemented for staff to do checks every hour. This policy was implemented when Staff A became aware that there was no call bell system in the MCU.	L 701		
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 1 sampled resident (Resident	L2501		

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L2501	Continued From page 2 #1). Findings include: A review of the incident report submitted to the Department dated 9/9/20 showed Resident #1 had a fall on 9/5/20 and sustained a fractured left hip. The facility did not have a functional call bell system. Resident #1 was transferred to the emergency room for evaluation and treatment. During an interview on 9/18/20, GG stated Resident #1 was admitted to the MCU. Resident #1 had been living at another Assisted Living Community but needed more care. GG stated that staff from the facility completed a pre-admission assessment. GG stated that Resident #1 used a rollator for ambulation but needed assistance to stand. On the day Resident #1 fell, Staff B was the manager on duty. GG stated Staff B told him/her that there had been some confusion as to what level of care Resident #1 needed at admission. GG stated Resident #1 had short term memory loss but had always used the call button for assistance at the previous facility. GG stated on the first night at the facility Resident #1 fell and fractured his/her hip. GG stated that the call bell at this facility was not working. GG stated that he/she was unaware the call bell was not working. GG stated that he/she would not have left Resident #1 at the facility if he/she had known the call bell system was non-functional During an interview on 9/21/20, GG stated staff had told him/her that there was a call bell system in the MCU. GG stated the call bell system was also referred to in the AA. A review of the file for Resident #1 showed he/she was admitted on 9/5/20 with diagnoses of	L2501		

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L2501	Continued From page 3 malignant neoplasm of the vulva, lung, bones, pain, hypertension. The 8/31/20 Physician's Medical Evaluation (PME) form showed Resident #1 needed assistance with ambulating, bathing, dressing, eating, grooming, toileting. Resident #1 needed supervision in transferring. The PME also showed that Resident #1 needed assistance from staff during the night for incontinent care and intermittent confusion. A review of the Memory Care Quality of Life Assessment dated 8/12/20 , completed by Staff C showed Resident #1 required assistance from 1 or more persons with ambulation. Resident #1 was incontinent of bowel and/or bladder and required assistance to appropriately manage personal toileting and hygiene care. The assessment showed Resident #1 had no history of wandering or exit seeking behavior. Resident #1 had random behaviors and was confused at times. A review of the nurses' notes (NNs) dated 9/5/20 at 2:40 p.m. showed Resident #1 arrived at the facility with family. Resident #1 ambulated with a rollator walker. The NN's also noted that Resident #1 needed assistance with Activities of Daily Living (ADLs) and toileting. Further review of the NN's dated 9/28/20 showed that at 10:00 p.m., Resident #1 had dinner with his/her family. The family left after dinner. At 10:30 p.m., Resident #1 was found on the floor, complaining of a broken hip. Staff called a hospice nurse. The hospice nurse arrived at 11:10 p.m., assessed the resident and Resident #1 was sent to the emergency room for evaluation and treatment. A review of the hospice interdisciplinary care plan	L2501		

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L2501	Continued From page 4 dated 9/28/20, showed Resident #1 ambulated using an assistance device and only with assistance of staff. Resident #1 needed assistance of staff to the toilet. A review of the 9/2020 work schedule showed Staff D and Staff E were on duty 9/5/20 3:00 p.m. to 11:00 p.m. Census in the MCU was 8 residents. During an interview on 9/21/20, Staff A stated the call bell system in the MCU never had been functional. Staff A stated there were pull cords in the rooms but they were not hooked to a system. Staff A stated they never told families that there was a call bell system in the MCU. Staff A stated Resident #1 had worn a call pendant at a previous facility and would activate the pendant when help was needed. Staff A stated they do not have such a system. Staff A stated that staff were available to observe residents and provide help when needed. During an interview on 9/24/20, Staff A stated a new policy was implemented after Resident #1 fell and Staff A realized there was no call bell system in the MCU. The new policy was for staff to do hourly checks on residents. instead of the previous policy of checking the residents every two hours. During an interview on 9/28/20 at 9:00 a.m., Staff C stated that he/she did a phone pre-admission assessment of Resident #1. Staff C stated that the staff from the previous facility reported that Resident #1 was very independent, could call for help when needed. Staff C stated Resident #1 had no history of falls so he/she did not do a fall assessment.	L2501		

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L2501	Continued From page 5 During another interview on 10/2/20 at 9:00 a.m., Staff C stated his/her last day of employment at the facility was 2 days before Resident #1's admission. Staff C stated that he/she left the resident file, which included the needs assessment, and the medications in the medication room in he MCU. Staff C stated that the medication room was locked when the medication technician or nurse are not in the room. Staff C also stated that care aides had access to the care plans when the room was unlocked. During an interview on 9/28/20 at 9:30 a.m., II stated that Resident #1 was going to need more assistance than the facility could provide, and he/she would ask family to consider a new placement. II stated Resident #1 was incontinent during the night. II stated that sometimes Resident #1 was found in the bathroom without calling for assistance. II stated Resident #1 did not have a history of falls. During an interview on 10/1/20, Staff D stated he/she was on duty 9/8/20. Staff D stated he/she saw Resident #1 in bed during 8:00 p.m. rounds sounded asleep so Staff D did not wake the resident for toileting. Staff D stated during the 10:00 p.m. rounds, he/she found Resident #1 on the floor in the doorway between the bedroom and bathroom. Resident #1's walker was next to him/her so Staff D assumed the resident had used it to walk to the bathroom. Staff D stated he/she called the nurse on duty who came to assess Resident #1 and then called the ambulance. Staff D stated no one had given him/her any information on the needs of Resident #1. If he/she had known Resident #1 needed assistance in ambulating he/she would have awakened the resident and walked him/her to the	L2501		

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L2501	Continued From page 6 bathroom. Staff D stated the care plans were kept locked in the medication room. Staff D stated he/she never saw a care plan or needs assessment for Resident #1. During an interview on 10/2/20, JJ stated when a new resident is admitted to the MCU, the medication technician would inform resident and/or family what care the resident needed. JJ stated he/she took the initiative to talk to the medication technicians, residents and families to ask about care needed. The care plans were kept in the charts locked in the medication room. Care aides were not allowed to look in the charts. JJ stated he/she would not know what care a new resident needed if he/she did not take the initiative to ask the medication technician, residents or family. JJ stated he/she was not on duty when Resident #1 was admitted. During an interview on 10/2/20, Staff B stated he/she was on duty 9/5/20 when Resident #1 was admitted to the MCU. Staff B stated he/she told Staff D that Resident #1 walked with a rolling walker and needed stand by assist with ambulation. Staff B stated he/she assumed the caregiver would understand to keep an eye on a new resident. Staff B stated that apparently Resident #1 used a call pendant at the previous facility and had success in its use. Staff B stated he/she did not know at the time that the call bell system in the MCU did not work.	L2501		

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{L 0000}	>>>>The purpose of this visit on was to investigate intake #GA00208098. The investigation started on 9/18/20 and was completed 10/2/20.

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{L 0701} SS= J	>>>>Based on record review and interview, the facility failed to implement their policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules. Findings include: A review of the admission agreement (AA) for Resident #1 showed that an emergency call device in bedroom/bathroom area would be provided. A review of the Resident Suite Inspection Checklist on 9/5/20 for Resident #1 showed an E Call System was ready in his/her suite. During an interview on 9/13/20, GG stated on the first night of Resident #1 at the facility, he/she fell and fractured his/her hip. The call bell system at this facility was not working. GG stated he/she was unaware the call bell system was not working and would not have left Resident #1 there if he/she had known. During an interview on 9/21/20 , GG stated the facility staff told him/her there was a call bell system in the memory care unit (MCU). GG stated the call bell system was also included in the AA. During an interview on 9/21/20, Staff A stated there was no working call bell system in the MCU and there never has been. Staff A stated there were pull cords in the rooms, but they were not hooked to a system. Staff A stated they never told families there was a call bell system in the MCU. During an interview on 9/24/20, Staff A stated staff were to do checks every 2 hours on residents. Staff A stated that after Resident #1 fell and fractured his/her hip, a policy was implemented for staff to do checks every hour. This policy was implemented when Staff A became aware that there was no call bell system in the MCU.

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{L 2501} SS= J	>>>>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 1 sampled resident (Resident #1). Findings include: A review of the incident report submitted to the Department dated 9/9/20 showed Resident #1 had a fall on 9/5/20 and sustained a fractured left hip. The facility did not have a functional call bell system. Resident #1 was transferred to the emergency room for evaluation and treatment. During an interview on 9/18/20, GG stated Resident #1 was admitted to the MCU. Resident #1 had been living at another Assisted Living Community but needed more care. GG stated that staff from the facility completed a pre-admission assessment. GG stated that Resident #1 used a rollator for ambulation but needed assistance to stand. On the day Resident #1 fell, Staff B was the manager on duty. GG stated Staff B told him/her that there had been some confusion as to what level of care Resident #1 needed at admission. GG stated Resident #1 had short term memory loss but had always used the call button for assistance at the previous facility. GG stated on the first night at the facility Resident #1 fell and fractured his/her hip. GG stated that the call bell at this facility was not working. GG stated that he/she was unaware the call bell was not working. GG stated that he/she would not have left Resident #1 at the facility if he/she had known the call bell system was non-functional During an interview on 9/21/20, GG stated staff had told him/her that there was a call bell system in the MCU. GG stated the call bell system was also referred to in the AA. A review of the file for Resident #1 showed he/she was admitted on 9/5/20 with diagnoses of malignant neoplasm of the vulva, lung, bones, pain, hypertension. The 8/31/20 Physician's Medical Evaluation (PME) form showed Resident #1 needed assistance with ambulating, bathing, dressing, eating, grooming, toileting. Resident #1 needed supervision in transferring. The PME also showed that Resident #1 needed assistance from staff during the night for incontinent care and intermittent confusion.

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	ALC000603	A. BUILDING B. WING	10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COMMONS	1 PEACHTREE DRIVE SAVANNAH, GA 31419

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	A review of the Memory Care Quality of Life Assessment dated 8/12/20 , completed by Staff C showed Resident #1 required assistance from 1 or more persons with ambulation. Resident #1 was incontinent of bowel and/or bladder and required assistance to appropriately manage personal toileting and hygiene care. The assessment showed Resident #1 had no history of wandering or exit seeking behavior. Resident #1 had random behaviors and was confused at times. A review of the nurses' notes (NNs) dated 9/5/20 at 2:40 p.m. showed Resident #1 arrived at the facility with family. Resident #1 ambulated with a rollator walker. The NN's also noted that Resident #1 needed assistance with Activities of Daily Living (ADLs) and toileting. Further review of the NN's dated 9/28/20 showed that at 10:00 p.m., Resident #1 had dinner with his/her family. The family left after dinner. At 10:30 p.m., Resident #1 was found on the floor, complaining of a broken hip. Staff called a hospice nurse. The hospice nurse arrived at 11:10 p.m., assessed the resident and Resident #1 was sent to the emergency room for evaluation and treatment. A review of the hospice interdisciplinary care plan dated 9/28/20, showed Resident #1 ambulated using an assistance device and only with assistance of staff. Resident #1 needed assistance of staff to the toilet. A review of the 9/2020 work schedule showed Staff D and Staff E were on duty 9/5/20 3:00 p.m. to 11:00 p.m. Census in the MCU was 8 residents. During an interview on 9/21/20, Staff A stated the call bell system in the MCU never had been functional. Staff A stated there were pull cords in the rooms but they were not hooked to a system. Staff A stated they never told families that there was a call bell system in the MCU. Staff A stated Resident #1 had worn a call pendant at a previous facility and would activate the pendant when help was needed. Staff A stated they do not have such a system. Staff A stated that staff were available to observe residents and provide help when needed. During an interview on 9/24/20, Staff A stated a new policy was implemented after Resident #1 fell and Staff A realized there was no call bell system in the MCU. The new policy was for staff to do hourly checks on residents. instead of the previous policy of checking the residents every two hours. During an interview on 9/28/20 at 9:00 a.m., Staff C stated that he/she did a phone pre-admission assessment of Resident #1. Staff C stated that the staff from the previous facility

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reported that Resident #1 was very independent, could call for help when needed. Staff C stated Resident #1 had no history of falls so he/she did not do a fall assessment.

During another interview on 10/2/20 at 9:00 a.m., Staff C stated his/her last day of employment at the facility was 2 days before Resident #1's admission. Staff C stated that he/she left the resident file, which included the needs assessment, and the medications in the medication room in he MCU. Staff C stated that the medication room was locked when the medication technician or nurse are not in the room. Staff C also stated that care aides had access to the care plans when the room was unlocked.

During an interview on 9/28/20 at 9:30 a.m., II stated that Resident #1 was going to need more assistance than the facility could provide, and he/she would ask family to consider a new placement. II stated Resident #1 was incontinent during the night. II stated that sometimes Resident #1 was found in the bathroom without calling for assistance. II stated Resident #1 did not have a history of falls.

During an interview on 10/1/20, Staff D stated he/she was on duty 9/8/20. Staff D stated he/she saw Resident #1 in bed during 8:00 p.m. rounds sounded asleep so Staff D did not wake the resident for toileting. Staff D stated during the 10:00 p.m. rounds, he/she found Resident #1 on the floor in the doorway between the bedroom and bathroom. Resident #1's walker was next to him/her so Staff D assumed the resident had used it to walk to the bathroom. Staff D stated he/she called the nurse on duty who came to assess Resident #1 and then called the ambulance. Staff D stated no one had given him/her any information on the needs of Resident #1. If he/she had known Resident #1 needed assistance in ambulating he/she would have awakened the resident and walked him/her to the bathroom. Staff D stated the care plans were kept locked in the medication room. Staff D stated he/she never saw a care plan or needs assessment for Resident #1.

During an interview on 10/2/20, JJ stated when a new resident is admitted to the MCU, the medication technician would inform resident and/or family what care the resident needed. JJ stated he/she took the initiative to talk to the medication technicians, residents and families to ask about care needed. The care plans were kept in the charts locked in the medication room. Care aides were not allowed to look in the charts. JJ stated he/she would not know what care a new resident needed if he/she did not take the initiative to ask the medication technician, residents or family. JJ stated he/she was not on duty when Resident #1 was admitted.

During an interview on 10/2/20, Staff B stated he/she was on duty 9/5/20 when Resident #1 was admitted to the MCU. Staff B stated he/she told Staff D that Resident #1 walked with a rolling walker and needed stand by assist with ambulation. Staff B stated he/she assumed the caregiver would understand to keep an eye on a new resident. Staff B stated that apparently Resident #1 used a call pendant at the previous facility and had success in its use. Staff B stated he/she did

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	not know at the time that the call bell system in the MCU did not work.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor | Frank W. Berry, Commissioner

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

March 19, 2020

Parsant Desai, Administrator
Savannah Commons
1 Peachtree Drive
Savannah, GA 31419

Dear Mr. Desai:

IMPORTANT NOTICE, PLEASE READ: Any new rule and/or rule changes are available on the Department of Community Health (DCH) website at www.dch.georgia.gov. Select Healthcare Facility Regulation, then Laws and Regulations, and then Assisted Living Communities (25 or more residents). Please check the DCH website periodically for updates, information, and training opportunities.

Report of Most Recent Survey

On March 4, 2020, staff from the Department of Community Health (DCH), Healthcare Facility Regulation Division (HFRD), Personal Care Home Program, conducted a survey of Savannah Commons, located at 1 Peachtree Drive, Savannah, Georgia. Based on the survey findings, four violations of the Rules and Regulations for Assisted Living Communities, Chapter 111-8-63, were cited. Attached is a copy of the Survey Report. Please note that the survey findings are subject to supervisory review. Any violations cited may be deleted, corrected and/or additional violations cited based on that review. Any revisions of the survey report will be sent under separate cover.

Notice to Correct Violations / Enforcement Action

Pursuant to the Rules and Regulations for Assisted Living Communities, Chapter 111-8-63, and the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, Chapter 111-8-25, the Department may impose a sanction for the violation of any rule. Notice to the governing body regarding the imposition of a sanction will be sent under separate cover. Failure to correct violations or failure to maintain compliance once corrections are made may result in further sanctions, including revocation of your permit.

Posting of the Inspection Report and Plan of Correction (POC)

A copy of this inspection report and plan of correction, if required, must be displayed in the assisted living community in a location that is routinely used by the community to communicate information to residents and visitors. The POC should not be sent to the Department.

To be acceptable, the POC must:

- Identify the methods and procedures to be used in the correction of the deficiencies;
- Identify the dates corrections have or will be completed; and
- Specify how the residence will monitor the corrections to achieve and maintain compliance.

The date by which corrections must be completed shall be no later than thirty (30) days from the date of the survey.

Statement of Disagreement

If the administrator/on-site manager disagrees with any of the deficiencies cited in this report, he/she may send a written statement of disagreement to the Regional Director to be reviewed. This must be submitted within ten (10) days of receipt of this letter and must include documentation, witness statements or other evidence showing the deficiency was cited in error. Failure to submit appropriate evidence will not alter the survey results.

If you have any questions or if we may be of assistance, please do not hesitate to call or write us.

Sincerely,

Irene Hubbard, Regional Director
Personal Care Home Program
Healthcare Facility Regulation Division

Attachment

cc: Facility File

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
	ALC000603	A. BUILDING: _____ B. WING _____	03/04/2020

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L 000	Initial Comments. >>>>The purpose of this visit was to conduct the compliance inspection and to investigate intake #GA00202842 and GA00202991. On site visits were made 3/3/20 and 3/4/20 and the investigation was completed 3/4/20.	L 000		
L 925 SS=D	111-8-63-.09(12) Criminal History Background Checks- Employees Criminal History Background Checks for Employees Required. Prior to serving as an employee, other than a director of an assisted living community, the community must obtain a satisfactory records check determination for the person to be hired in compliance with the provisions of O.C.G.A. § 31-7-250 et seq. or specific rules passed pursuant to the statute. This RULE is not met as evidenced by: >>>>Based on record review and staff interview, the community failed to obtain a criminal records check determination in compliance with the provisions of O.C.G.A 31-7-250- et seq. for 1 of 5 sampled staff (Staff E). Findings include: A review 3/3/20 of staff files showed Staff E, hired 8/19/19, had no documentation of a criminal records check determination. During an interview on 3/4/20 at 10:00 a.m. Staff B stated Staff E had not had a local criminal records check.	L 925		
L2010 SS=J	111-8-63-.20(3) Community Administration of Medications.	L2010		

State of GA, Healthcare Facility Regulation Division

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L2010	Continued From page 1 Community Administration of Medications. Where the residents either are not capable of self-administration of medications or choose not to self-administer medications with assistance or supervision, the assisted living community must provide medication administration services to the residents in accordance with physicians' orders, the needs of the residents and these rules. This RULE is not met as evidenced by: ****>>>>Based on observation and record review, the facility's staff failed to follow the written doctor's order for 1 of 5 sampled residents (Resident #2). Findings include: A review of the file for Resident #2 on 3/4/20 showed, admitted, 1/22/20 with diagnoses of diabetes and hypertension. A review of the 2/2020 Medication Assistance Record showed Resident #2 was to receive Humalog 10 units before or after each meal and adjust the dose to sliding scale. The prescribed sliding scale was as follows: 61-200 0 units 201-250 4 units 251-300 6 units 301-350 8 units 351-400 10 units 401-800 10 units Call physician if less than 60 or more than 800. Resident #2's 2/2020 blood sugar log showed on 2/10/10 at 4:30 p.m. blood sugar was 547 and 8 units of Humalog was given. According to the sliding scale 10 units should have been given.	L2010		

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L2010	Continued From page 2 During an interview on 3/4/20 at 11:30 a.m., Staff G stated he/she gave Resident #2 the wrong amount of Humalog.	L2010		
L3002 SS=D	111-8-63-.30(2)(a) Reports to the Department. The serious incidents that must be reported to the Department include the following: (a) any accidental or unanticipated death not directly related to the natural course of the resident's underlying medical condition; ... This RULE is not met as evidenced by: >>>>Based on record review and staff interview, the facility failed to ensure that any accidental/unanticipated deaths were reported to the Department within 24 hours after the incident occurred for 1 of 1 sampled residents (Resident #1). Findings include: A review of the file for Resident #1 on 3/4/20 showed nurses notes dated 2/10/20 , showed the resident was found unresponsive by staff . CPR was begun and 911 was called. Resident #1's spouse, they lived together, was present. Resident #1 was pronounced dead and the funeral home picked up the body at 9:00 a.m. A review of the Department records showed no documentation this unanticipated death was reported by the facility. During an interview on 3/4/20 at 11:00 a.m. Staff B stated this death was not reported to the Department.	L3002		

State of GA, Healthcare Facility Regulation Division

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B 504 SS=D	111-8-12-.05(1)(d) Records Check Application. A records check application shall be required: (d) For each direct access employee, upon application for employment or prior to placement in the position; This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure direct care staff hired after October 1, 2019 had the required criminal background check upon employment or prior to placement in the position for 2 of 5 sampled staff (Staff C and Staff D). Findings include: A review of the staff files on 3/3/20 showed Staff C, hired 12/16/19 and Staff D, hired 11/25/19, had no documentation of a criminal background check upon employment. During an interview on 3/4/20 at 10:30 a.m. Staff A stated Staff C and Staff D had not had criminal background checks done.	B 504		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State of GA, Healthcare Facility Regulation Division

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B 504 SS=D	111-8-12-.05(1)(d) Records Check Application. A records check application shall be required: (d) For each direct access employee, upon application for employment or prior to placement in the position; This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure direct care staff hired after October 1, 2019 had the required criminal background check upon employment or prior to placement in the position for 2 of 5 sampled staff (Staff C and Staff D). Findings include: A review of the staff files on 3/3/20 showed Staff C, hired 12/16/19 and Staff D, hired 11/25/19, had no documentation of a criminal background check upon employment. During an interview on 3/4/20 at 10:30 a.m. Staff A stated Staff C and Staff D had not had criminal background checks done.	B 504		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE