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	04/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOCIAL AT SAVANNAH, THE	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 intakes #GA00231865, #GA00232239, and #GA00233098.
{L 2513} SS= D	>>>> Based on record review and interviews, the facility failed to ensure that each resident has the right to be free from actual or threatened physical or chemical restraints and the right to be free from isolation, corporal, or unusual punishment including interference with the daily functions of living, for 1 of 4 sampled residents (Resident #1). Findings include: A review of an incident report (IR) submitted to the Department on 1/26/2023, and another incident report maintained by the facility showed an allegation of restraint after Staff C blocked the apartment door of Resident #1 for about five (5) minutes with a heavy reclining chair to keep Resident #1 from going inside other residents' apartments and from urinating in those apartments. IR showed no injury was sustained by Resident #1. IR showed the incident occurred on 1/12/2023 between the 11:00 p.m. to 7:00 a.m. shift, but Staff A found out about the incident on 1/23/2023 from Staff D, who witnessed the incident. IR showed Staff C confirmed the allegation on 1/25/2023. IR showed Staff C's employment was terminated immediately on 1/25/2023. During an interview on 4/6/2023 at approximately 1:55 p.m., Staff A stated Resident #1, who was a memory care unit resident, became aggressive when staff tried to redirect him/her. Staff A stated it became very difficult for Staff C to handle the situation. However, Staff A stated instead of notifying him/her, Staff C decided to take care of the situation on his/her own. Staff A stated Staff C's decision to barricade the apartment door of Resident #1 to keep the Resident from wandering and messing around the other residents' rooms was inappropriate. Staff A terminated Staff C's employment on 1/25/2023. On the other hand, in the case of Staff D, Staff A stated he/she made Staff D understand the issue of restraint or seclusion should be reported immediately to him/her. Staff A stated Staff D was not reprimanded, but Staff D left the facility on 2/14/2023 for personal reasons. Staff A stated the social worker for Resident #1 agreed that Resident #1 was no longer appropriate to be retained at the facility. Staff A stated Resident #1 was moved to a psych center in another town on 2/16/2023 because of aggressiveness, difficulty

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	to redirect and manage him/her by the team. Staff A stated a family member of Resident #1 was notified about the incident and the decision to discharge the resident. Staff A stated a family member of the resident did not complain, but he/she expressed understanding of the situation. A review of the file for Staff C, hired on 6/18/2014, showed documentation of completed training on Resident's Rights. Further review of the file showed no documentation of other disciplinary actions were filed against Staff C. A review of the file for Resident #1, admitted 4/19/2022, showed diagnoses of dementia, diabetes mellitus, hypertension. Resident #1 had a medical history of hallucination and post-traumatic stress disorder. Resident #1 required supervision in all ADLs, except for toileting where he/she required hygiene assistance, and for dressing where the resident required total help. Further review of the file showed no restraint was required for Resident #1 since the resident was not a danger to himself/herself and others.