

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">PCH009872</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">09/12/2019</p>
NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS		STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
(A 000)	Opening Comments. >>>>The purpose of this visit was to conduct the initial inspection. No rule violations were cited as a result of this inspection.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS		STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
(A 000)	Opening Comments. >>>>The purpose of this visit was to investigate intake # GA00199745.		
(A 1919) SS= J	<p>111-8-62-.19(4)(b) Addl Req(s) for Spec Memory Care Units/Homes.</p> <p>The memory care unit or special care unit must be designed to accommodate residents with severe dementia or Alzheimer ' s Disease in a home-like environment which includes the following: ...</p> <p>(b) Secured outdoor spaces and walkways which are wheel chair accessible and allow residents to ambulate safely but prevent undetected egress.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>****>>>>Based on observation and interview the facility failed to have the memory care unit include secured outdoor spaces. Findings include:</p> <p>A review of the facility Incident Report (IR) showed documentation that Resident#1 was last seen at 5:40 PM in the memory care unit on 9/7/19. The IR further detailed that Resident #1 had eloped and was brought back to the community by law enforcement and the fire department after being seen laying on the ground 200 yards from the facility near a pharmacy.</p> <p>A review of the file for Resident #1 showed documentation that he/she resided at the memory care unit and ambulated with a walker.</p> <p>During a tour of the facility on 10/08/19 at 1:00 p.m., Resident #1 was observed in the memory</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS		STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
{A 2502} SS= J	<p>care unit ambulating with a walker, well groomed and had a cap on. Resident #1 said he/she did not remember the incident. The memory care unit courtyard had one door which led toward the outside street and parking lot area and had a security key pad and the door opened when the code was applied.</p> <p>During an interview on 10/0 8/19 at 2:30 P.M., Staff A said prior to the incident involving Resident #1 wandering off from the facility, the memory care unit courtyard door had no security keypad lock on and the door was easily opened by pressing the red button next to it. Staff A said Resident #1 resided at the memory care unit on 09/07/19 and eloped through the unsecure door on the courtyard of the memory care unit.</p> <p>111-8-62-.25(1)(a) Supporting Residents' Rights.</p> <p>Each resident must receive care, and services which must be adequate, appropriate, and in compliance with applicable federal and state law and regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>****>>>>Based on record review and interview, the facility failed to ensure each resident received care and services which were adequate, appropriate and in compliance with applicable federal and state law and regulations. Findings include:</p> <p>A review of the facility Incident Report (IR) and Chart Notes showed documentation that on 09/07/19 Resident#1 was last seen at 5:40 PM in the memory care unit, and a few hours later Resident #1 was found lying on the ground 200 yards from the facility near a pharmacy. Resident #1 was returned to the facility by the police and fire department. The facility sent Resident #1 to the hospital for evaluation and then he/she was returned to the facility without injuries.</p> <p>During the tour of the facility on 10/08/19 at 1:00 p.m., Resident #1 was observed in the memory care unit ambulating with a walker. Resident #1 said he/she did not remember the incident.</p> <p>During an interview on 10/08/19 at 2:30 P.M., Staff A said on 09/07/19, Resident #1 eloped from the memory care unit. Staff A said Resident #1 was last seen around 5:45 p.m. Staff A further stated that no staff had noticed that Resident #1 had eloped. Staff A said he/she did not know at what time the resident was found by the police on 09/07/19.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/08/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS		STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
Empty space for ID PREFIX TAG	Empty space for SUMMARY STATEMENT OF DEFICIENCIES		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
---	---

(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
--------------------	--	---------------	---	--------------------

A 000	Opening Comments. >>>>The purpose of this visit was to investigate intake # GA00200896.	A 000		
A1001 SS=J	111-8-62-.10(1) Staffing. The home must maintain a minimum on-site staff to resident ratio of one awake direct care staff person per 15 residents during waking hours and one awake direct care staff person per 25 residents during non-waking hours where the residents have minimal care needs. However, the home must staff above these minimum on-site staff ratios to meet the specific residents ' ongoing health, safety and care needs. This RULE is not met as evidenced by: ****>>>> Based on record review and interview, the facility failed to staff the home above the minimum on-site staff ratios to meet the specific residents' ongoing health, safety and care needs. Findings include: A review of the facility's 11/19 staffing schedule showed an average of three (3), one (1) care staff in memory care, one (1) care staff in personal care, and one (1) medication Tech for both units, worked in from 10:00 p.m. to 6:00 a.m. On 11/4/19 and 11/5/19 one (1) care staff and 1 medication tech worked. A review of the Law Enforcement Incident Report dated, 11/6/19 showed Resident #05 reported a sexual assault that involved Resident #07 occurred the night of 11/5/19 A review of the file for Resident #1, admitted 10/14/19, diagnosed with dementia, hypertension, hyperlipidemia, and hypothyroid and required	A1001		

State of GA Inspection Report LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
---	---

(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
--------------------	--	---------------	---	--------------------

A1001	<p>Continued From page 1</p> <p>placement in specialized memory care unit with controlled access/egress due to at risk of engaging in unsafe wandering and other unsafe activities.</p> <p>A review of the file for Resident #2, admitted 11/8/17, diagnosed with dementia with behavioral disturbances. Resident #2's physician evaluation dated, 10/31/17 showed Resident #2 required redirection, reality orientation, and required placement in specialized memory care unit with controlled access/egress due to at risk of engaging in unsafe wandering and other unsafe activities. A review of the "individual service plan" dated, 11/19/19 showed Resident #2 was at risk for wandering and required supervision to prevent unsafe wandering.</p> <p>A review of the file for Resident #3 showed diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and required placement in specialized memory care unit with controlled access/egress due to at risk of engaging in unsafe wandering and other unsafe activities. A review of Resident #3's "Safety Assessment" dated, 11/11/19 showed Resident #3 was at risk for wandering and falls. A review of Resident #3's "Individual Service Plan, 11/11/19 showed no documentation of facility intervention and plan for safety due to wandering.</p> <p>A review of the facility's "Secure Care Disclosure" dated, 11/7/17 showed the facility's special care unit provided 24 hour awake staff to provide protective care, increased staffing, watchful oversight to meet scheduled and unscheduled needs, provision and oversight of personal supportive services based on care plan, and staffing patterns allowed for additional individualized attention.</p>	A1001		
-------	---	-------	--	--

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
--	---

(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
--------------------	--	---------------	---	--------------------

A1001	<p>Continued From page 2</p> <p>During an interview, BB stated 3 staff worked in memory care from 6:00 a.m. to 2:00 p.m., 2 staff worked 2:00 p.m. to 10:00 p.m., and 2 staff worked 10:00 p.m. to 6:00 a.m. BB stated the facility had been short of staff.</p> <p>During an interview at 1:20 p.m., Staff C stated Resident #2 wandered up and down the halls at night.</p> <p>During an interview at 1:30 p.m., Staff D stated Resident #2 constantly wandered at night. Staff D stated he/she found Resident #2 in another resident's room getting undressed, he/she redirected Resident #2 backed to his/her room, and Resident #2 displayed aggressive behavior towards him/her. Staff D stated Resident #3 was found lying in bed with Resident #4 and was redirected to his/her room. Staff D stated Resident #2 displayed physical and verbal aggressive behavior at times. Staff D stated Resident #3 and Resident #4 reported that Resident #2 came into their rooms.</p> <p>During an interview at 1:40 p.m., Resident #4 stated Resident #2 came into his/her room twice, once he/she got undressed, and the second time he/she laid in his/her bed. Resident #4 stated he/she did not do anything to him/her, but he/she was afraid.</p> <p>During an interview at 2:05 p.m., Staff A stated Resident #2 wandered throughout the memory care unit at night and was physically aggressive towards female staff. Staff A stated the facility was staffed appropriately according to ratio.</p>	A1001		
-------	--	-------	--	--

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/03/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
---	---

(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
--------------------	--	---------------	---	--------------------

A2502	Continued From page 3	A2502		
A2502 SS=D	<p>111-8-62-.25(1)(a) Supporting Residents' Rights.</p> <p>Each resident must receive care, and services which must be adequate, appropriate, and in compliance with applicable federal and state law and regulations.</p> <p>This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure each resident received care and services which were adequate, appropriate and in compliance with applicable federal and state law and regulations. Findings include:</p> <p>A review of the facility's "Statement of Residents' Rights" Exhibit F showed the residents had the right to receive adequate, appropriate care and services.</p> <p>During an interview at 1:30 p.m., Staff D stated Resident #2 constantly wandered at night. Staff D stated Resident #3 was found lying in bed with Resident #4 and was redirected to his/her room.</p> <p>During an interview at 1:40 p.m., Resident #4 stated Resident #2 came into his/her room uninvited twice, once he/she got undressed, and the second time he/she laid in the bed with his/her. Resident #4 stated he/she did not do anything to him/her, but he/she was afraid.</p> <p>During an interview at 2:05 p.m., Staff A stated Resident #2 wandered throughout the memory care unit at night. Staff A stated he/she was aware of Resident #2's previous incident of going into a residents' room and getting in the bed with the resident.</p>	A2502		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/03/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
---	---

(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
A2508 SS=J	<p>111-8-62-.25(1)(d) Supporting Residents' Rights.</p> <p>Each resident must have the right to enjoy privacy in his or her room; home personnel and others must respect this right by knocking on the door before entering the resident's room.</p> <p>This RULE is not met as evidenced by: ****>>>Based on record review and interviews, the facility failed to ensure each resident was allowed the right to enjoy privacy in his/her room. Findings include:</p> <p>A review of the facility's "Statement of Residents' Rights" Exhibit F showed the residents had the right to enjoy privacy in his/her room.</p> <p>A review of Resident #2's "Solve Wellness Review", dated 11/19/19 showed he/she was at risk for wandering, required supervision to prevent unsafe wandering.</p> <p>During an interview at 1:40 p.m., Resident #4 stated Resident #2 came into his/her room uninvited twice, once he/she got undressed, and the second time he/she laid in the bed with his/her. Resident #4 stated he/she did not do anything to him/her, but he/she was afraid.</p> <p>During an interview at 2:05 p.m., Staff A stated Resident #2 wandered throughout the memory care unit at night. Staff A stated he/she was aware of Resident #2's previous incident of going into a residents' room and getting in the bed with the resident.</p>	A2508		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/03/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
---	---

(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
A2601	Continued From page 5	A2601		
A2601 SS=D	<p>111-8-62-.26(1) Procedures for Change in Resident Condition.</p> <p>In case of an accident or sudden adverse change in a resident's physical condition or emotional adjustment, a home must 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 home must retain a record of all such accidents or sudden adverse changes and the home ' s response in the resident's files.</p> <p>This RULE is not met as evidenced by: >>>>Based on record review and staff interview, the facility failed to document a record of incidents, accidents or sudden adverse changes. Findings include:</p> <p>A review of the law enforcement incident report dated, 11/6/19 showed Staff A reported an incident that involved Resident #2 where the resident laid in the bed with another resident at night and Resident #2 became physically aggressive, held a staff by his/her shoulders and pushed the staff against a wall.</p> <p>A review of the facility's incident report showed no documentation of an incident that involved Resident #2 lying in bed with another resident, and no incident report that showed Resident #2 became physically aggressive towards a staff.</p> <p>During an interview, AA stated the facility provided no incident report of Resident #2 lying in bed with another resident at night and the incident was not reported to law enforcement agency.</p> <p>During an interview at 1:30 p.m., Staff D stated</p>	A2601		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
---	---

(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
A2601	Continued From page 6 Resident #3 was found lying in bed with Resident #4 and was redirected to his/her room. During an interview at 2:05 p.m., Staff A stated he/she was aware of Resident #2's previous incident of going into a residents' room and getting in bed with the resident and the facility did not have a incident report and incident was not reported to law enforcement.	A2601		
A3002 SS=D	111-8-62-.30(2) Reporting. The personal care home must report a serious incident using the complaint intake system and location designated by the Department within 24 hours following the occurrence of a serious incident or the home 's learning that a serious incident involving a resident may have occurred. This RULE is not met as evidenced by: >>>> Based on record review and staff interview, the facility failed to report a serious incident involving a resident within 24 hours following the occurrence for 2 of 2 resident (Resident #05 and Resident #07). Findings include: A review of the facility's incident report dated, 11/6/19 showed Resident #07 performed sexual acts on Resident #05 and law enforcement was notified. During an interview at 2:05 p.m., Staff A stated he/she followed the company's directive and did not report the incident to the Department because the incident was not reportable.	A3002		
A3004 SS=D	111-8-62-.30(2)(b) Reporting.	A3004		

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH009872	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/03/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
---	---

(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
A3004	<p>Continued From page 7</p> <p>... The serious incidents that must be reported to the Department include the following: ...</p> <p>(b) Any serious injury to a resident that requires medical treatment.</p> <p>This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to report to the Department a serious injury to a resident that required medical treatment for 1 of 1 sampled residents (Resident #2). Findings include:</p> <p>A review of the facility's incident report dated, 10/5/19 and 10/7/19 showed Resident #2 was sent to the hospital due to an unwitnessed fall, change in gait, and discomfort.</p> <p>A review of the facility's "progress notes" for Resident #2 showed, on 10/7/19 Resident #2 was sent to the hospital and diagnosed with a right Clavicle Fracture.</p> <p>During an interview at 2:05 p.m., Staff A stated he/she reported Resident #2's injury/fracture to the Department and no documentation of the reporting was provided.</p>	A3004		

State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH006954	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2019
--	---	--	--

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
--	---

(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
--------------------	--	---------------	---	--------------------

P 436	<p>Continued From page 1 following: ...</p> <p>(d) Ensure that a written plan of care is developed for the individual with a disability by a licensed healthcare professional in accordance with the written orders of an attending physician, an advanced practice registered nurse or physician's assistant working under a nurse protocol agreement or job description respectively, and that such plan of care specifies the frequency of training and evaluation requirements for the proxy caregiver and when additional training will be required for new duties added to the written plan of care for which the proxy caregiver has not been previously trained. The licensed facility must either use the written plan of care form made available by the Department or another form containing all the required elements. ...</p> <p>This RULE is not met as evidenced by: Based on record review and administrator interview, the facility failed to ensure the plan of care included the written orders of a physician, advanced practice registered nurse or physician's assistant for a resident(Resident #1). Finding include:</p> <p>A review of the file for Resident #1, showed no documented plan of care for Proxy caregiver services.</p> <p>During an interview at 10:50 a.m., Staff B stated he/she and other staff assist Resident #1 with his/her medication daily. Staff document on the Medication Administration Record each time the medication is given.</p> <p>During an interview at 4:58 p.m. Staff A stated</p>	P 436		
-------	--	-------	--	--

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH006954	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2019
--	---	--	--

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE, ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
--	---

(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
--------------------	--	---------------	---	--------------------

P 401 111-8-100-.04(2) Written Informed Consent.
SS=D
Written Informed Consent. No licensed facility will permit a proxy caregiver to provide health maintenance activities by or through the licensed facility unless the individual with a disability, or the legally authorized representative has executed an informed consent. ...

P 401

This RULE is not met as evidenced by:
>>>>Based on record review and interview, the facility failed to execute an informed consent for a proxy caregiver to provide health maintenance activities for an individual with a disability before providing those services for a resident (Resident #1). Findings include:

A review of the file for Resident #1 showed no documented informed consent for proxy caregiver services.

During an interview at 10:50 a.m., Staff B stated he/she and other staff assist Resident #1 with his/her medication daily. Staff document on the Medication Administration Record each time the medication is given.

During an interview at 4:58 p.m. Staff A stated that he/she was not aware of the inform consent for proxy caregiver services was not completed.

P 436 111-8-100-.04(4)(d) Services Through Proxy
SS=D Caregivers.

Where the licensed facility employs, contracts or refers proxy caregivers to deliver health maintenance activities to individuals with disabilities receiving services through the licensed facility, the licensed facility must do the

P 436

State of GA Inspection Report
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCH006954	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2019
--	---	--	--

NAME OF PROVIDER OR SUPPLIER HERITAGE OF SANDY PLAINS	STREET ADDRESS, CITY, STATE ZIP CODE 3039 SANDY PLAINS ROAD MARIETTA, GA 30066
--	--

(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
--------------------	--	---------------	---	--------------------

P 436	Continued From page 2 that he/she was not aware the plan of care for proxy caregiver services was not completed.	P 436		
-------	---	-------	--	--