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
	ALC000552	A. BUILDING B. WING	**09/02/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR LAKE BRIDGEMILL	**131 HOLLY STREET** **CANTON, GA 30114**

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{L 000}	Initial Comments. >>>>The purpose of this visit was to investigate intake #GA00216187, GA00216705, GA00216678. The investigation was started on 08/09/21, on-site visit was made to the facility on 8/11/21, and was completed on 09/02/2021.
{L 0711} SS= D	111-8-63-.07(2)(j) Owner Governance. At a minimum, the policies and procedures that are developed must provide direction for the staff and residents on the following: ... (j) the investigation and reporting of abuse, neglect, exploitation of residents, residents' wandering away from the community, accidents, injuries and changes in residents' conditions to required parties; ... This REQUIREMENT is not met as evidenced by:

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>>>>Based on observation, record review and interviews, the facility's governing body failed to at a minimum,

investigate a residents' wandering away from the community for 1 of 3 sampled residents (Resident #1). Findings include:

A review of the facility's Incident Report dated 07/018/2021 showed documentation that on 07/18/2021 around 1:00 p.m., Resident #1 was observed near a roadway in front of the facility.

A review of the file for Resident #1 showed that he/she was diagnosed with dementia and resided at the memory care unit (MCU) and wandered often and needed supervision.

During a tour of the facility on 08/11/21 around 1:00 p.m., Resident #1 was observed in the MCU and had no recall of how he/she had exited the facility and how long he/she had been wandering outside of the facility on 07/18/2021. Staff A and Staff B were present as the tour continued. In the rear section of the facility, a courtyard gate was observed and it opened to a parking lot. A security electronic device key was required to unlock the courtyard gate, however when the gate was unlocked with the electronic device key, it did not relock effectively and the gate had to be slammed several times to get it locked.

During interviews on 08/11/21, AA, CC, DD said the memory care's courtyard gate's lock system had not locked properly for months unless the gate was slammed several times, and although they had notifed Staff B and Staff A, nothing was done. CC and DD said even after the elopement incident with Resident #1, the governing body did not fix the lock to the courtyrd gate..

During an interview on 08/11/22021 at 1:15 p.m., Staff B said the gate's lock system had not been working effectively for months and remained ineffective after the incident.

During an interview on 08/11/2021 at 2:35 p.m., Staff A stated Resident #1 eloped from the memory care unit on 07/18/2021. Staff A said he/she did not know how Resident #1 eloped from the MCU.

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{L 1700}
SS= J

111-8-63-.17(1) Services in the Community.

The assisted living community must provide assisted living, including protective care and watchful oversight, which meets the needs of the residents it admits and retains.

This REQUIREMENT is not met as evidenced by:

****>>>>Based on observation, record review and interview, the facility failed to provide protective and watchful oversight to meet the needs of the residents for 1 of 3 sampled residents (Resident #1). Findings include:

A review of the facility incident report dated 07/018/2021 provided documentation to show that on 07/18/2021 around 1:00 p.m., Resident #1 was observed by the receptionist and another individual walking outside, in front of the facility near the roadway. Resident #1 was redirected and returned to the facility. No injuries were reported.

During a tour of the facility on 08/11/21 around 1:00 p.m., Resident #1 was observed wandering in the MCU. Resident #1 said he/she did not remember the incident and did not know how long he/she had been wandering on a road. Staff A and Staff B were present as the tour continued. In the rear section of the facility a courtyard gate was observed and it opened to a parking lot. A security electronic device key was required to unlock the courtyard gate, however when the gate was unlocked with the electronic device key, it did not relock effectively and the gate had to be slammed several times to get it locked. Staff B was observed unlocking and locking the gate. Staff B in three demonstrated attempts had to slam the courtyard gate roughly 3-4 times in order to activate the lock.

During an interview on 08/11/2021 at 1:40 p.m., AA said he/she was working on 07/18/21 in the MCU. AA said that around 1:00 p.m., BB called and said Resident #1 had left the MCU and was

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outside in the middle of the road. AA said he/she had not seen Resident #1 and did not know the resident had exited the facility after lunch. AA said he/she had seen Resident #1 at lunch time around 11:30 a.m., and then at around 1:00 p.m. AA stated after the incident, Resident #1 was a wandering and needed re-direction and supervision by memory care staff. AA stated the resident exited the MCU when no one was watching him/her.

During an interview on 08/11/2021 at 2:15 p.m., BB said that on 07/18/2021 around 1:00 p.m., he/she was outside in front of the building talking to a family member. BB stated that he/she witnessed an older individual in the middle of the two way road, in front of the building, trying to cross the road. BB said he/she did not recognize the individual but the family member was able to recognize the resident and said the older individual was Resident #1 who resided at the MCU. BB said the family member ran towards the road and assisted Resident #1 off the road toward the building. BB further stated that Resident #1 was found approximately 500 feet away from the facility entrance on a two way road . BB said the scene was terrifying because Resident #1 was standing in the middle of the two way road and cars were passing by and Resident #1 could have been easily hit by a car.

During an interview on 08/11/21, at 1:55 p.m., CC said he/she and AA worked in the MCU on the 7/18/21 at the time of the incident. CC said that around 11:30 a.m., Resident #1 had his/her lunch, and then wandered in the MCU, and told staff " he/she was going to church". CC said while he/she was busy with cleaning after lunch, he/she did not notice Resident #1 in the MCU. CC said he/she believed Resident #1 walked out of the memory care unit after lunch when staff did not watch him/her. CC heard that AA received a call from BB with an alert that Resident #1 was found in the middle of the road and someone brought Resident #1 back inside the facility. CC said he/she went inside the courtyard and saw that the courtyard gate was wide open.

During an interview on 08/11/2021 at 2:35 p.m., Staff A confirmed Resident #1 eloped from the MCU on 07/18/2021. Staff A said he/she was thankful that Resident #1 was not hit by a car and this incident did not turn into a tragedy.

A review of the file for Resident #1 showed that he/she was diagnosed with dementia and resided in the MCU. Physician Evaluation Form for Resident #1 on the date of admission 03/04/2019 showed that Resident #1 required to be in the MCU as he/she was at risk of unsafe wandering.

According to the Georgia Weather Calendar on 07/18/2021, the outside temperature was 84 degrees Farenheit at the peak.

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{L 1801}
SS= D

111-8-63-.18(1)(b) Requirements for Memory Care Services.

An assisted living community which serves residents with cognitive deficits which place the residents at risk of eloping, i.e. engaging in unsafe wandering activities outside the assisted living community must do the following: ...

(b) Utilize appropriate effective safety devices, which do not impede the residents' rights to mobility and activity choice or violate fire safety standards, to protect the residents who are at risk of eloping from the premises.

This REQUIREMENT is not met as evidenced by:

>>>>Based on observation, record review and interviews, the facility failed to utilize effective safety devices to protect residents who were at risk of eloping from the facility's memory care unit for 1 of 3 sampled residents (Resident #1). Findings include:

A review of the facility incident report provided documentation to show that on 07/18/2021 Resident #1 wandered outside of the facility's memory care unit and was found on a two way road in front of the facility.

According to the resident file, Resident #1 was diagnosed with dementia and resided in the MCU since 2019. Resident #1's Physician Evaluation Form at date of admission (03/04/2019) stated that Resident #1 required a memory care unit as he/she was at risk for unsafe wandering.

During the tour of the facility on 08/11/21 around 1:00 p.m., Resident #1 was observed wandering in the MCU. Resident #1 said he/she did not remember the incident and did not know how long he/she had been wandering on a road. Staff A and Staff B were present as the tour continued. In the rear section of the facility a courtyard gate was observed and it opened to a parking lot. A

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security electronic device key was required to unlock the courtyard gate, however when the gate was unlocked with the electronic device key, it did not relock effectively and the gate had to be slammed several times to get it locked. Staff B was observed unlocking and locking the gate. Staff B in three demonstrated attempts had to slam the courtyard gate roughly 3-4 times in order to activate the lock.

During an interview on 08/11/2021 at 1:40 p.m., AA said the courtyard's gate did not lock unless it was slammed hard. AA said he/she noticed the problem for 5-6 months and had notifed the managers and nothing was done to address the issue.

During an interview on 08/11/2021 at 1:25 p.m., DD said he/she worked at the facility for more than 12 months and the memory care unit's courtyard gate leading out to the back parking lot did not lock and he/she had notified all the managers, but was given the directive to just slam the gate hard for several times.

During an interview on 08/11/21, at 1:55 p.m., CC said the courtyard gate in the MCU did not lock unless it was slammed several times and staff used that gate to return to the MCU after they took the trash out. CC said he/she worked at the facility for several months and the gate did not lock in one attempt.

During an interiew on 08/11/22021 at 1:15 p.m., Staff B said he/she had noticed that the gate only locked after being slammed several times since he/she started this job in May 2021. Staff B added he/she should have had fixed the gate, but he/she did not.

During an interview on 08/11/2021 at 2:35 p.m., Staff A said he/she was not aware that the gate in the MCU courtyard did not lock effectively.

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