| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | ALC000588 | A. BUILDING<br>B. WING | 04/06/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MANOR LAKE GAINESVILLE | 2900 MCEVER ROAD<br>GAINESVILLE, GA 30504 |

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| {L 0000} | The purpose of survey was to investigate #GA00210203, #GA00210310, #GA00210294, and #GA00210545. The investigation started on 12/22/20 and was completed on 4/5/2021. |
| {L 0706}<br>SS= D | <<<<Based on record review and interview, the facility failed to implement policies and procedures that provide direction for the staff and residents on training and ongoing evaluation of staff, including specialized training if memory care is offered for 9 of 9 sampled staff. Findings include:<br><br>A review of the files for Staff C, hired 8/4/2020; Staff D, hired 8/17/2020, Staff F, hired 8/31/202, Staff G hired 6/1/2020, Staff H, hired 3/5/2020, Staff I hired 5/1/2020; Staff J, hired 7/29/2020, and Staff L hired 10/25/2020 showed no training on dementia stages/diagnosis, safety maintenance of residents, behavior management skills, communication skills, role of family, environment modifications, development in diagnosis and therapy, recognize cognitive, and physical changes, and safety maintenace of residents.<br><br>A review of the file for Staff E hired 10/30/2020, showed no training on recognize cognitive and physical changes, safety maintenance of residents, behavior management skills, communication skills, role of family, environment modifications, and development in diagnosis and therapy.<br><br>During an interview on 3/24/2021 at 4:31 p.m., GG stated he/she had did not have memory care |

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| | training and was told to start working in the unit.<br><br>During an interview on 3/30/2021 at 1:43 p.m., CC stated that he/she did not have any training in memory care.<br><br>During an interview on 3/23/2021, Staff E stated that he/she did not receive several trainings for the memory care.<br><br>During an interview on 4/6/2021 at 9:00 a.m., Staff A stated that currently staff have trained on memory care. |
| {L 1300}<br>SS= D | >>>>Based on record review, observation and interview, the facility failed to ensure clean and sanitary conditions which might pose a health or safety risk to the residents and staff. Findings include:<br><br>During an interview on 12/22/2020, AA stated on Saturday, 10/31/2020 at 7:00 am, he/she received a call from staff stating that Resident #1 had fallen and was found on the floor. AA stated the relative of Resident #1 demanded to entrance into the facility. AA stated that Staff A allowed the relative entrance into the facility for only 15 minutes. AA stated that the relative told him/her that Resident #1 had a skin tear on his/her right wrist and the right ankle was swollen and bandaged from a cut.<br><br>During an interview on 3/23/2021 at 11:04 a.m., HH stated that Resident #1 and Resident #2 shared a room. HH stated that Resident #2 would move items around in the room. HH stated that both Resident #1 and Resident #2 had combative behaviors. |

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| {L 1709} | During an interview on 3/24/2021 at 4:31 p.m., GG stated that the room of Resident #1 had clothing on the floor and was cluttered. GG stated the bedsheets were dirty with urine and dried feces on it. GG stated that the roommate of Resident #1 had a lot clothing on his/her area.<br><br>A review of the staff notes for Resident #1 showed on 10/31/20 at 6:30 (no a.m. or p.m. documented) that the resident was observed on the floor when staff walked in the resident ' s room. On 11/21/20, Resident #1 was observed on the floor by the foot side of the bed.<br><br>A review of the facility communication log showed on 10/31/2020 (no a.m. or p.m. time was documented) that Resident #1 was on the floor by the bed. The med tech was notified and dressing was placed on his/her left arm. Another communication note showed that Resident #1 was on the floor in the bathroom. One large dressing was places on the left arm and one small dressing was put on both arms.<br><br>A review of the facility incident reports showed on 10/31/2020 at 6:00 a.m. that Resident #1 had an unwitnessed fall. Resident #1 was observed on the floor beside the bed. The resident had hit his/her head and his/her elbow had a skin tear. Resident #1 was bleeding. The comments/ resolution outcome final disposition showed that the resident needed frequent monitoring for safety and ensure clutter free environment. Another incident report showed on 10/31/2020 at 6:00 a.m. that Resident #1 had an unwitnessed fall. Resident #1 was observed on the floor. The resident sustained a bruise, skin tear, and was bleeding. The comments/ resolution outcome final disposition showed that the resident needed frequent checks and the residence to remain clutter free. The third incident report dated on 11/21/2020 at 5:00 p.m. showed that a staff found Resident #1 on the floor. Resident #1 was observed by a caregiver at the foot of the bed. The comments/ resolution outcome final disposition showed to continue frequent checks to ensure safety, proper footwear, and ensure clutter free environment.<br><br>During an interview on 4/6/2021 at 10:00 a.m., Staff A stated that the relative of Resident #1 was upset because of the conditions of the room and the staff cleaned the room. |

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| SS= D | ****>>>>Based on record review and interview, the facility failed to update the care plan more frequently where the needs of the resident change substantially for Resident #1. Findings include:<br><br>A review of the care plan dated 10/26/20, for Resident #1 showed the resident had a fall risk. The resident needed assistance as needed to prevent injury (assistive device, area free of clutter, etc.) All staff were responsible for helping. The care plan was not updated until 11/23/2020, when the resident was in the hospital.<br><br>A review of the staff notes for Resident #1 showed on 10/31/2020 at 6:30 (no a.m. or p.m. documented), the resident was observed on the floor when staff walked in the resident 's room. On 11/21/2020 at 5:00 p.m., Resident #1 was observed on the floor by the foot side of the bed.<br><br>A review of the facility communication log showed on 10/31/2020 (no a.m. or p.m. time was documented) that Resident #1 was on the floor by the bed. The med tech was notified, and dressing was placed on the left arm of the resident. Another communication note dated 10/27/2020 showed that Resident #1 was observed on the floor in the bathroom. EMS was called and the resident was sent out.<br><br>A review of the facility incident reports showed on 10/31/2020 at 6:00 a.m. that Resident #1 had an unwitnessed fall. Resident #1 was observed on the floor beside the bed. The resident had hit his/her head and elbow. The resident had a skin tear and was bleeding. The comments/resolution outcome final disposition showed the resident needed frequent monitoring for safety and to ensure a clutter free environment. Another incident report showed on 10/31/2020 at 6:00 a.m. that Resident #1 had an unwitnessed fall. Resident #1 was observed on the floor. The resident sustained a bruise, skin tear, and was bleeding. The comments/ resolution outcome final disposition showed that the resident needed frequent checks and the residence to remain clutter free. The third incident report dated on 11/21/2020 at 5:00 p.m. showed that a staff found Resident #1 on the floor. Resident #1 was observed by a caregiver at the foot of the bed. The comments/ resolution outcome final disposition showed to continue frequent checks to ensure safety, proper footwear, and ensure clutter free environment.<br><br>During an interview on 12/22/2020, AA stated on Saturday, 10/31/2020 at 7:00 am, he/she received a call from staff stating that Resident #1 had fallen and was found on the floor. AA stated the relative of Resident #1 demanded to entrance into the facility. AA stated that Staff A allowed the relative entrance into the facility for only 15 minutes. AA stated the relative told him/her that Resident #1 had a skin tear on his/her right wrist and the right ankle.<br><br>During an interview on 3/17/2021 at 10:00 a.m., BB stated that the facility did not update the care |

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|---|---|
| MANOR LAKE GAINESVILLE | 2900 MCEVER ROAD<br>GAINESVILLE, GA 30504 |

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| | plans and assessments when the resident had three incidents of falls.<br><br>During an interview on 4/6/2021 at 9:00 a.m., Staff A stated he/she was aware of the incidents and the plans was not updated |
| {L 1922}<br>SS= D | ****>>>>Based on 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 staff on duty at all times to meet the needs of the residents. Findings include:<br><br>A review of the files for Staff C, hired 8/4/2020; Staff D, hired 8/17/2020, Staff F, hired 8/31/2020; Staff G hired 6/1/2020; Staff H, hired 3/5/2020; Staff I hired 5/1/2020; Staff J, hired 7/29/2020, and Staff L hired 10/25/2020 showed no training on dementia stages/diagnosis, safety maintenance of residents, behavior management skills, communication skills, role of family, environment modifications, development in diagnosis and therapy, recognize congnitive, and physical changes, and safety maintance of residents. A review of the file for Staff E hired 10/30/2020, showed no training on recognize cognitive and physical changes, safety maintenance of residents, behavior management skills, communication skills, role of family, environment modifications, and development in diagnosis and therapy.<br><br>During an interview on 3/24/2021 at 4:31 p.m., GG stated he/she had not received any proper memory care unit training and never went to orientation.<br><br>During an interview on 3/23/2021, Staff E stated that he/she did not receive several trainings for the memory care unit.<br><br>During an interview on 4/6/2021 at 9:00 a.m., Staff A stated that staff will receive training during staff orientation. |

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| {L 2049}<br>SS= D | >>>>Based on record review and interview, the facility failed to update the Medication Administration Record (MAR) each time the medication was for Resident #1. Findings include:<br><br>A review of November 2020 (MAR) medication administer record for Resident #1 showed empty cells for 11/11/2020 and 11/19/2020 for Levothyroxine. The resident was prescribed to take one tablet once daily for hypothyroidism.<br><br>During an interview on 3/17/2021 at 10:00 a.m., BB stated that Resident #1 did not received his/her medication as directed.<br><br>During an interview on 3/30/2021 at 1:43 p.m., CC stated that MAR of Resident #1 would have empty cells because staff would give the medications late and did not update the MAR. CC stated that staff did not explain why the resident received the medication late, 30 minutes after prescribed times.<br><br>During an interview on 4/6/2021 at 9:00 a.m., Staff A stated okay. |
| {L 2311}<br>SS= D | |

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| | <<<<Based on record review and interview, the facility failed to ensure to the clean the residents' private living spaces periodically and as needed to ensure that the space does not pose a health hazard. Findings include:<br><br>During an interview on 12/23/2020, on 11/21/2020, AA stated that he/she found Resident #1 lying on the bed in soiled sheets with no bed covers. AA stated that the mattress and side rail had dried blood, urine, and excrement all over them.<br><br>During an interview on 3/20/2021 at 10:00 a.m., EE stated on 11/21/2020, the room of Resident #1 and Resident #2 was not clean. EE stated that Resident #2 would often bowel movements in the room. EE stated that the room was not clean.<br><br>During an interview on 3/24/2021 at 10:00 a.m., GG stated around 11/19/2020 stated the room was not clean. GG stated the room had clothes on the floor. GG stated that urine, dried feces, and the room was often cluttered. GG stated that food was on the floor.<br><br>During an interview on 3/30/2021 at 1:43 p.m., CC stated that Resident #1 had fallen on the floor. CC stated that he/she saw on the clothes.<br><br>During an interview on 4/6/2021 at 9:00 a.m., Staff A stated that a family went and saw the how the room looked. Staff A stated that a staff cleaned it. |
| {L 2514}<br>SS= D | >>>>Based on record review and interview, the facility failed to ensure each resident have the |

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| | right to reasonable safeguards for the protection and security of his or her personal property brought into the facility for Resident #1. Findings include:<br><br>During an interview on 3/16/2021, Staff B stated that eye glasses of Resident #1 were kept the medication cart. Staff B stated that the glasses were taken off at nights and given to the resident in the mornings. Staff B stated that the resident kept losing them.<br><br>During an interview on 3/24/2021 at 4:31 p.m., GG stated the eyes glasses of Resident #1 were not on the medication cart. GG stated that some residents' clothing were mixed in other residents, and the residents did not receive their clothing.<br><br>During an interview on 3/30/2021 at 1:43 p.m., CC stated that Resident #1 had gloves and eyeglasses, but they immediately disappeared. CC stated that residents' items were missing often.<br><br>During an interview on 4/6/2021 at 9:00 a.m., Staff A stated okay. |
| {L 3001}<br>SS= D | >>>>Based on record review and interview, the facility failed to report to the Department within 24 hours any serious injury to a resident that requires medical attention for Resident #1. Findings include:<br><br>A review of incident reports submitted to the Department showed no incident reports dated 10/28/2020 and 11/21/2020. Resident #1 had an unwitnessed fall on 10/28/2020 and went to the hosptial. Another incident report dated 11/21/2020 showed that Resident #1 had an unwitnessed fall and went to the hospital on 11/22/2020.<br><br>A review of the facility incident reports showed on 10/28/2020 at 12:35 a.m., a staff found Resident #1 on the floor. Resident #1 was observed bleeding from the head and left elbow. Resident #1 stated that he/she was packing his/her bags. The spouse of Resident #1 was called |

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| | at 12:45 a.m. and wanted the resident to go the hospital. The resident was transported to the hospital by EMS.<br><br>A review of the 911 report showed on 10/28/2020 that Resident #1 was found on the floor. Resident #1 told staff of pain to the back of the head, left elbow, and left hip. Staff stated that they heard Resident #1 screaming and came to his/her room. Resident #1 was lying on the floor with blood on the floor. Resident was transported to the hospital.<br><br>During an interview on 12/14/2020, AA stated that he/she received a phone call on Wednesday, 10/28/2020, around 12:30 a.m. that Resident #1 had fallen and was found on the floor with a head wound. AA stated that Resident #1 had been transported to a hospital for evaluation.<br><br>During an interview on 3/30/2021 at 1:43 p.m., CC stated that Resident #1 had fall on the floor on 10/28/2020.<br><br>During an interview on 4/6/2021 at 9:00 a.m., Staff A stated that the incident reports was not submitted to the department. |