

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALC000196	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER OAKS AT SHILOH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 7955 MAJORS ROAD CUMMING, GA 30041	
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{0000}	Initial Comments. The purpose of this visit was to investigate intake #GA50007534. The investigation began on 12/11/25, an onsite visit was made on 12/11/25, and the investigation was completed on 12/18/25.		
{0906} SS= D	111-8-63-.09(3)(b) Init Trng for Staff Prov. Hands-On Pers Svcs. [The] administrator must ensure that staff hired to provide hands-on personal services to residents receive training within the first 60 days of employment which includes the following: ... (b) current certification in cardiopulmonary resuscitation where the training course required return demonstration of competency; ... This REQUIREMENT is not met as evidenced by: >>>>Based on interview and record review, the facility failed to ensure all direct care staff received initial orientation training within the first thirty (30) days of caring for residents independently, that, at a minimum, included emergency first aid and Cardiopulmonary Resuscitation (CPR) for 3 sampled staff (Staff B, Staff C, Staff D). The findings included:		

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	Record review of the personnel file for Staff B showed a date of hire of 12/9/24; Staff C (date of hire 2/20/23) and Staff D (date of hire 8/7/23) did not have record of current CPR and emergency first aid certification. On 12/11/25 at 12:53 p.m., Staff A stated Staff B, Staff C, and Staff D worked in memory care. Staff A stated she would look to see if they had CPR or First aid certification and send the documentation. No documentation has been received. {0911} 111-8-63-.09(5) Training Hours Req During First Yr Employ. SS= D Training Hours Required During First Year of Employment. All staff offering hands-on personal services to the residents, including the administrator or on-site manager, must satisfactorily complete a total of at least twenty-four (24) hours of continuing education within the first year of employment as a direct care worker. The courses offered must be relevant to assigned job duties and include such topics as cardiopulmonary resuscitation and first aid certifications, utilizing standard precautions in working with aging residents, working with residents with Alzheimer's or other cognitive impairments, working with persons who have developmental disabilities or persons who have mental illness, providing social and recreational activities, understanding legal issues, performing necessary physical maintenance, fire safety, housekeeping activities, recognizing and reporting abuse, neglect and exploitation, preparing and serving food safely, preserving the dignity and rights of residents receiving care to make meaningful choices, providing and documenting medication assistance, or other topics as determined necessary by the Department to support compliance.		

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	This REQUIREMENT is not met as evidenced by: >>>>Based on record review and staff interview, the facility failed to ensure staff had the training hours required during the first year of employment. All staff offering hands-on personal services to the residents, including the administrator or on-site manager, must satisfactorily complete a total of at least twenty-four (24) hours of continuing education within the first year of employment as a direct care worker. The courses offered must be relevant to assigned job duties and include such topics as cardiopulmonary resuscitation and first aid certifications, utilizing standard precautions in working with aging residents, working with residents with Alzheimer's or other cognitive impairments, working with persons who have developmental disabilities or persons who have mental illness, providing social and recreational activities, understanding legal issues, performing necessary physical maintenance, fire safety, housekeeping activities, recognizing and reporting abuse, neglect and exploitation, preparing and serving food safely, preserving the dignity and rights of residents receiving care to make meaningful choices, providing and documenting medication assistance, or other topics as determined necessary by the Department to support compliance for 3 of 3 sampled staff (Staff B, Staff C, and Staff D). The findings included: A review of Staff B's personnel file showed a date of hire of 12/9/24. Staff B's file did not include the required 24 hours of training within the first year.		

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{1709} SS= D	A review of Staff C's personnel file showed a date of hire of 2/20/23. Staff C's file did not include the required 24 hours of training in the first year. A review of Staff D's personnel file showed a date of hire of 8/7/23. Staff D's file did not include the required 24 hours of training in the first year. On 12/11/25 at 12:53 p.m., Staff A stated Staff B, Staff C, and Staff D worked in memory care. There was no training record for Staff D. Staff A provided the training transcripts for Staff B and Staff C, which did not meet the Department's minimum training requirement. 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 memory care center. This REQUIREMENT is not met as evidenced by: >>>>Based on observation, interview, and record review, the facility failed to revise the written care plan at least annually and more frequently where the needs changed significantly, including multiple falls and admission to hospice		

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	care for 1 of 1 sampled Resident (Resident #1). The findings included: A review of records revealed Resident #1 was admitted to the facility on [REDACTED]. The physician's medical evaluation dated 11/5/24 showed diagnoses of dementia and hypertension. Resident #1 required memory care and medication management. Resident #1 was independent with ambulation and transferring. On 12/11/25 between 10:00 a.m.-11:45 a.m., Resident #1 was observed wandering in the memory care unit. Resident #1 was unsteady, off balance when the position was changed or turned. No staff were within direct line of sight of Resident #1. Resident #1 was disheveled, unshaven, and malodorous. A review of the records revealed Resident #1 was admitted to hospice services on [REDACTED]. Record review of the care plan for Resident #1 showed a focus for falls, initiated 9/9/25. The established goal was to encourage the resident to call for assistance with what was needed. Intervention was to anticipate the needs of the learning resident.		

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	Record review of facility documents reveals Resident #1 sustained multiple falls on 10/1/25 at 9:20 a.m., 10/1/25 at 6:48 p.m., 10/4/25 at 6:58 a.m., 10/6/25 at 11:30 a.m., 10/15/25 at 1:25 a.m., 11/15/25 at 5:30 a.m., 11/18/25 at 12:10 p.m., 11/23/25 at 11:00 a.m., 11/23/25 at 4:14 p.m. No new care plan interventions were added following the falls. On 12/11/25 at 10:59 a.m., during an interview and review of the care plan, Staff A stated the care plan did not get updated after the falls or following the hospice admission. On 12/18/25 at 11:30 a.m., during an interview, AA stated Resident #1 started falling in April 2025. AA stated he/she thought there was a nurse on duty at the facility that would assist if there was a fall. AA stated that hospice was called to admit the resident, and they checked on Resident #1. The Medication Technicians (MT) are unable to give updates. AA stated that when the MTs are asked, they stated they don't have any information about what occurred on other shifts.		

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{1931} SS= D	111-8-63-.19(1)(d)4. Ongoing Training. Ongoing Training. Direct care staff shall complete a minimum of eight (8) hours of specialized training in dementia care on an annual basis. This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure staff completed ongoing required training, which consisted of a minimum of eight (8) hours of specialized training in dementia care on an annual basis. for 3 of 3 staff sampled (Staff B, Staff C, and Staff D) The findings included: A review of the personnel file for Staff B showed a date of hire of 12/9/24. Staff C's date of hire was 2/20/23, and Staff D's date of hire was 8/7/23. There was no record of a minimum of 8 hours of specialized training in dementia care annually.		

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	On 12/11/25 at 12:53 p.m., Staff A stated Staff B, Staff C, and Staff D worked in memory care. Staff A stated he/she provided the training transcript showing what training had been completed. There was no training record for Staff D.		
{2512} SS= D	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 REQUIREMENT is not met as evidenced by: >>>>Based on the interview and record review, the facility failed to ensure that 1 of 1 sampled residents (Resident #1) was free from physical abuse, neglect, and exploitation. The findings included:		

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	A review of records revealed Resident #1 was admitted to the facility on [REDACTED]. The physician's medical evaluation dated 11/5/24 showed diagnoses of dementia and hypertension. Resident #1 required memory care and medication management. Resident #1 was independent with ambulation and transferring. Resident #1 was admitted to hospice services on [REDACTED]. On 12/11/25 at 10:00 a.m., a general tour was conducted of the memory care unit. Staff B and Staff E were observed sitting on the memory care sofa, each on a personal cell phone. Staff E stated the census was 6. Staff E stated that Resident #1 had not yet been assisted out of bed. A tour of Resident #1's room with Staff B, and Staff E found Resident #1 sitting quietly on the bedside. Resident #1 seemed confused, appeared disheveled, and unshaven, and the room was malodorous. Staff B stated Resident #1 had not had breakfast or his/her 7:00 a.m., medications yet. Staff B assisted Resident #1 in putting on shoes, and Resident #1 willingly ambulated to the dining area. Staff I was called to bring Resident #1's medications. On 12/11/25 at 10:05 a.m., Staff I brought Resident #1's medications (Amlodipine 5mg, Aspirin 81 mg, Cetirizine HCL 10 mg, Multivitamin, Thiamine 100 mg, Divalproex 125mg, Quetiapine 100mg, Haloperidol 5mg) scheduled for 7:00 a.m. Staff I stated Resident #1 was sleeping, so he/she did not wake him for		

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	medication. Staff I stated there was no order to hold medication if Resident #1 was sleeping. Staff I stated he/she was a Certified Medication Technician and was not trained to hold medications if a resident was sleeping. On 12/11/25 at 10:59 am, Staff A stated that staff were told to let the resident sleep, but stated there was no progress note, no care plan specification, or order that reflected that direction. Facility investigation dated 10/26/25 stated Staff D was involved in willful misconduct by attempting to retrieve a walkie talkie from an agitated memory care resident (Resident #1) that resulted in Staff D being pushed. The investigation stated family reported Staff C and Staff D brought Resident #1 to his/her room, were very rough and dragged him into the room, then put him into bed with force. Resident #1 had bruising to the right buttock, hip, and leg. The investigation stated there was no fall recorded between 10/22/25 and 10/24/25. Resident #1's family has informed the facility they heard two caregivers discussing a fall during that time frame. On 12/18/25 at 11:30 a.m., During an interview AA stated the family had placed cameras in Resident #1's room with permission from the facility. AA stated video footage showed on 10/18/25 at approximately 10:22p.m., 2 caregivers were at Resident #1's bedside. AA stated Staff E aggressively picked Resident #1 up and slung him/her into the bed. Resident #1 can be heard saying "that was uncalled for".		

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	AA stated video footage showed on 10/22/25 at approximately 8:29 p.m., two staff members one each side of Resident #1 holding him underneath his arms pulling him backwards against his will in his room and placed in bed. The resident can be hear cursing at staff as they tell him "lay down, lay down" and staff can be heard laughing as they exit the room. AA stated video footage showed on 10/24/25 at 8:01 a.m., two staff were observed assessing bruising noted to Resident #1's leg starting at the hip area and extending down the leg to behind the knee and can be heard saying it was probably from when he fell. AA stated he/she went to the facility and saw the bruising. AA stated he/she called the hospice agency and requested a nurse visit for assessment. AA stated Resident #1 was last seen by hospice on 10/22/25 in the morning, and there was no bruising or injury. AA stated no one called him/her to report any injury between 10/22/25 and 10/24/25, and was very upset when he/she saw the bruising. On 12/18/25 at 11:32 a.m., Staff G stated during a telephone interview AA called the on call service on 10/25/25 and reported a bruise. The on-call nurse met AA at the facility and documented a large hematoma to right hip, and bruising down the right leg. Staff G stated Resident #1 was last seen on 10/22/25 and there		

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	was no bruising. Staff G stated no injury was reported to the hospice agency or family. On 12/18/25 at 2:15 p.m., Staff D stated during a telephone interview Resident #1 pushed him/her and he/she fell. He was agitated and he was upset. Resident #1 took my walkie talkie and I asked him for it he got mad, and pushed me when I turned around. Resident #1 was rummaging through drawers in the dining area and then he sat down on the floor. Staff C tried to take him to the room to put him in bed. On 12/11/25 at 12:20 p.m., Staff A stated he/she was not informed of the incident with Resident #1 until the next day. Staff A stated he/she was told Resident #1 got a hold of Staff D's walkie talkie. Staff D reached to grab it from Resident #1 and Resident #1 pushed Staff D. Staff A stated Resident #1 independently walked back to his/her room. Shortly after that time Resident #1 was found wandering and laid down on the floor. Staff A stated Resident #1 was assisted to stand up but then refused to walk through the door so Staff C and Staff D walked him in. Staff A stated one girl had her hand on his back and was holding his arm linked with her arm and guided him in. Staff A stated I was not told what he was saying but the tone showed he did not want to follow the staff into the room. Both staff members have been allowed to return to work. Staff A stated as part of the investigation Resident #1 should have been allowed to stay on the floor because he was comfortable. Hospice was called to assess the bruising. Since there was no fall, no report to the department was made.		

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	On 12/11/25 at 10:30 a.m., During a memory care tour, Staff A verified there was no long term care ombudsman poster or reporting abuse and neglect sign. Staff A stated there was no grievance log, Staff A stated there was a complaint from Resident #1's family where resident was on the floor of the memory care unit and staff assisted Resident #1 to walk against his will. The two staff members involved are on leave not related to the incident. On 12/11/25 at 12:20 p.m., Staff A stated during an interview staff retraining titled "how to approach a resident with dementia to de-escalate a situation and abuse and neglect in Georgia was completed for 16 of 40 staff members.		