STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000544	A. BUILDING B. WING	01/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTIS FAYETTEVILLE	936 WEST LANIER AVENUE FAYETTEVILLE, GA 30214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{L 000}	Initial Comments. >>>>The purpose of this visit was to conduct a compliance inspection and to investigate intake #GA00201881. An on-site visit was made on 1/13/20 and the investigation was completed on 1/22/20.
{L 0912} SS= D	111-8-63-.09(6) Training. Ongoing Staff Training. Beginning with the second year of employment, staff providing hands-on personal services must have a minimum of sixteen (16) hours of job-related continuing education as referenced in paragraph 111-8-63-.09(5) above annually. For staff providing hands-on personal services in the memory care unit, at least two hours of the ongoing continuing education required each year must be devoted specifically to training relevant to caring for residents with dementia. This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure staff had 16 hours of continuing education units (CEUs) for 1 of 8 sampled staff (Staff C). Findings include: A review of training records for Staff C, hired 6/20/18, showed no documentation of 16 hours of CEUs. During an interview at 11:20 a.m., Staff A stated that Staff C did not complete his/her yearly training.
{L 1132} SS= D	111-8-63-.11(9)(a) Fire Safety. The assisted living community must comply with applicable fire and safety rules published by the Office of the Safety Fire Commissioner.

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	This REQUIREMENT is not met as evidenced by: >>>>Based record review and staff interview, the facility failed to comply with applicable fire and safety rules published by the Office of the Safety Fire Commissioner (one fire drill per quarter per shift). Findings include: A review of 1/2019 to 12/31/19 facility fire drills, showed there were no fire drills completed during the third shift on 1/2019, 3/2019, 5/2019, 8/2019, no fire drills on the second shift for 5/2019. Documented 2019 fire drills were as follows: 1/16/9 at 1:10 p.m., 1/30/19 at 9:50 a.m., 1/31/19 at 1:00 p.m., 2/26/19 at 3:30 p.m., 3/28/19 at 7:30 a.m., 5/9/19 at 9:25 a.m., and 10:40 a.m., 8/19/19 at 10 :42 a.m., and 4:40 p.m., 9/24/19 at 11:15 a.m., 10/21/19 at 2:23 p.m., and 4:00 p.m., 10/23/19 at 5:00 a.m., 12/17/19 at 1:30 p.m., 12/19/19 at 1:30 a.m., and 12/20/19 at 10:15 a.m. During an interview at 2:02 p.m., Staff A stated the facility did an audit in fall and found out that they were not in compliance with the fire drills.
{L 1314} SS= D	111-8-63-.13(14) Community Safety Precautions. Heated water must be made available by the assisted living community to the residents for their usage and must be comfortable to the touch but must not exceed 120 degrees Fahrenheit (F.). This REQUIREMENT is not met as evidenced by: >>>>Based on observation and staff interview, the facility failed to maintain heated water temperature in the facility that did not exceed 120 degrees Fahrenheit (F). Findings include: During a tour of the facility 8:48 a.m., the Department representative calibrated his/her thermometer in a cup of ice and registered at degrees F (32.9 degrees F minus 32 degrees F [freezing point] equals .9 degrees F), and this was witnessed by Staff G. At 8:50 a.m , the heated water temperature in the sink bathroom of the memory care unit bedroom registered at 123.3 degrees F minus .9 degrees F equals 122.4 degrees F.

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	During a tour of the facility 9:44 a.m., the heated water temperature in the sink bathroom of the second floor bedroom registered at 129.4 degrees F, and this was witnessed by Staff F. During an interview at 10:03 a.m., Staff H stated that he/she would reset the hot water calibration.
{L 2501} SS= D	111-8-63-.25(1)(a) Supporting Residents' Rights. The assisted living community must provide to each resident care and services which are adequate, appropriate, and in compliance with state law and regulations. This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interviews, the facility failed to ensure that each resident received care and services which were adequate, appropriate, and in compliance with state law and regulations for 4 of 6 sampled residents (Resident #2, Resident #3, Resident #4, and Resident #5). Findings include: A review of the facility incident report from 11/2019 to 1/13/2020, showed incident reports for the following residents: Resident #2: 1. On 12/17/19, Resident #2 who was a resident in the memory care unit was observed outside of the facility going towards a car. 2. On 12/31/19, Resident #2 eloped from the memory care unit. A review of the 12/31/19 incident report for Resident #2, showed that he/she was last seen by facility staff at 2:30 a.m. in his/her apartment, and at 4:30 a.m., the resident was escorted back to the facility by a police officer. Resident #3:

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	1. On 12/15/19, Resident #3 who was a memory care resdent went out the side door with another resident. Resident #4: 1. On 11/8/19, Resident #4 who was a memory care resident exited the building. Resident #5: 1. On 11/8/19, Resident #5 along with Resident #4 who were memory care resident exited. 2. On 11/29/19 Resident #5 went out the back door and no alarms went off to alert staff. A review of the 11/8/19 incident report for Resident #5, showed the alarm was not heard by the facility staff. The 11/8/19 incident report for Resident #5 also showed that the resident walked around the building and came to the front door of the memory care unit. A review of the file for Resident #2, admitted 2/12/19, diagnoses of Dementia and hyperlipidemia, showed an elopement management evaluation completed on 1/31/19 and 4/1/19, showing that the resident was high risk for elopement. A review of the file for Resident #3, admitted 1/25/19, diagnoses of Alzheimers, Dementia and Hypertension, showed an elopement management evaluation completed on 1/25/19, showing that the resident was high risk for elopement. A review of the file for Resident #4, admitted 2/28/19, diagnoses of Dementia, showed an elopement management evaluation completed on 2/12/19, showing that the resident was high risk for elopement. A review of the file for Resident #5, admitted 4/10/19, diagnoses of Alzheimers, anxiety, chronic constipation, Hypertension, Atrial fibrillation, and vitamin D deficiency, showed an elopement management evaluation completed on 4/9/19, showing that the resident was high risk for elopement. During an interview at 9:00 a.m., Staff A stated that Resident #2 was a high risk for elopement.

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	Staff A further stated that on 12/31/19, the facility staff did not know that Resident #2 had eloped from the facility, a police officer brought the resident back to the facility at 4:00 a.m. Staff A also stated that the memory care staff might had reset the alarm when the resident exited the facility on 12/31/19 without checking on residents. Staff A stated that the alarm company was called on 12/31/19, because there was a power surge. During an interview at 9:11 a.m., Staff F stated that Resident #2 was a exit seeker. Staff F further stated that the exit doors would open if the handle of the exit doors are held for a minute or so. Staff F further stated that the staff might had been in the bedroom and did not hear the alarm. During a tour of the facility at 9:18 a.m,. the lobby exit door handle was pulled for a minute, and the lobby exit door opened. During an interview on 1/17/20, FF stated on 12/31/19, after Resident #2 was brought back to the facility, Staff B informed him/her that the alarm on the exit doors had went off earlier, and he/she cleared the alarm without checking on the residents. During interview on 1/17/20, at 4:42 p.m., EE stated that staffing was increased in the memory care unit after the elopement of Resident #2. During an interview on 1/22/20, Staff B stated he/she was assigned to Resident #2 on 12/31/19. Staff B further stated that Resident #2 was a high risk for elopement. Staff A also stated he/she did not know that Resident #2 had exited the facility until a police officer brought the resident back to the facility at 4:30 a.m. Staff B stated that on 12/31/19, Resident #2 tried to eloped twice and he/she redirected the resident and notified the supervisor. Staff B stated that he/she did heard a sound on one of the exit door, however he/she did not do rounds to check on the residents.