STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC00675	A. BUILDING B. WING	02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE PARK MILTON	555 WILLIS ROAD ALPHARETTA, GA 30009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{L 0000}	>>>>The purpose of this visit was to investigate intake #GA00211456, #GA00211244 and #GA00211354. This inspection started on 1/21/21 and was completed on 2/9/21.
{L 0949} SS= D	>>>>Based on record review and interview, the facility failed to ensure that all persons who offered direct care to the residents on behalf of the assisted living community maintained awareness of each resident's normal appearance and must intervene, as appropriate, if a resident's state of health appears to be in jeopardy for 1 of 14 sampled residents (Resident #1). Findings include: A review of the police incident/investigation report revealed on 1/10/21 at 8:50p.m. DD was dispatched to the hospital regarding a missing person found. DD met EE and FF and was informed they responded to a welfare call near Wills Rd. and Hembree Rd. around 6:00p.m. regarding an elderly female (Resident #1) that might be in distress. Resident #1 was confused and did not know his/her name, address or any other information. EE and FF went to the facility and showed a picture of Resident #1 to the staff. The staff at the facility did not recognize the person in the picture. Then later that evening, the hospital received a call from the facility informing the hospital staff that Resident #1 did live at their facility and the facility staff realized Resident #1 was missing after doing a unit check on the residents in the home. DD spoke to Staff B via telephone and Staff B stated he/she was aware of Resident #1 being at the hospital and was on the phone with Resident #1's family informing them of what happened. Staff B called EE back and informed him/her someone would go to the hospital to take responsibility of Resident #1. Resident #1 was taken to get a CT Scan of his/her shoulder. When EE returned Staff B was waiting outside of Resident #1's room. Staff B told DD the staff did not recognize Resident #1 in the picture, they realized he/she was missing when the staff did their rounds. EE gave Staff B the case number and left Resident #1 under Staff B's care. Case #2101-000277. In an interview Staff B stated on 1/10/21 the police came to the facility and showed a picture of Resident #1 and asked did Resident #1 live at the facility. Staff B stated he/she looked at the

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	picture and did not recognize the person in the photo. Staff B stated when the staff did their unit checks they noticed Resident #1 was missing. Staff B stated he/she contacted the hospital and gave a description of Resident #1 and was told he/she was at the hospital. Staff B stated he/she went to the hospital and sat with Resident #1 until he/she was discharged. Staff B stated Resident #1's arm was in a sling because his/her shoulder was fractured. Staff B brought Resident #1 back to the facility. They arrived at 12:15a.m. on 1/11/21. A review of discharge papers from the hospital dated 1/10/21 revealed Resident #1 was admitted for altered mental status and evaluated and then diagnosed with Alzheimer's dementia and a closed fracture of proximal end of right humerus (the arm bone between your shoulder and elbow) and was discharged back to the facility with an arm sling and was provided with a prescription of Oxycodone 5-325 mg take 1 tablet by mouth every four hours as needed for severe pain (opioid analgesic prescribed for moderate to severe pain). The hospital discharge papers indicated that Resident #1 was administered Morphine by the hospital staff the evening of 1/10/21 at 7:46 p.m.
{L 1100} SS= D	>>>>Based on record review and interviews the facility failed to ensure the community was designed, constructed, arranged, and maintained so as to provide for all of the following: (a) health, safety, and well-being of the residents for 1 of 14 residents (Resident #1). Findings include: A review of the facilty's incident report showed documentation that on 1/10/21 Staff B was notifed Resident #1 was missing from the facility. Staff B called the hospital and gave a description of Resident #1 to see if Resident #1 was there. Staff B was told that an individual meeting that description was at the hospital. Staff B went to the hospital and brought Resident #1 back to the facility. According to the incident report CC was notified at 9:00p.m. on 1/10/21 and the incident report was written at 12:37a.m. on 1/11/21. A review of the police incident/investigation report revealed on 1/10/21 at 8:50p.m. DD was dispatched to the hospital regarding a missing person found. DD met EE and FF and was

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