

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ALC000032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER OAKS AT GRACEMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 4940 JOT EM DOWN ROAD CUMMING, GA 30041	
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{L 0000}	Initial Comments.		
{L 0701} SS= J	<p>>>>>The purpose of this visit was to conduct a follow-up visit. An onsite visit was made on 5/7/2025. The inspection was started on 5/7/2025 and the investigation was completed on 5/7/2025. No rule violations were cited as a result of this inspection.</p> <p>111-8-63-.07(2) Owner Governance. The governing body is responsible for implementing policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules.</p> <p>This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to implement policies, procedures and practices in the community that support the core values of dignity, respect, choice, independence and privacy of the residents in a safe environment and in accordance with these rules for one resident (Resident#1). Findings include:</p> <p>A review of the facility reported incident submitted to the Department on 11/17/24, showed documentation of a resident elopement involving Resident #1 (R1) which occurred on 11/17/24. According to the incident report, R1 resided on the first floor of the assisted living section and staff determined that R1 went missing on 11/17/24 between the hours of 8:30 a.m. and 11:13 a.m. R1 was found in a vacant car located across the street from the facility, on a private residential property unharmed. Resident #1 was transferred to the hospital for further evaluation by ambulance and then relocated to a different long term care</p>		

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	<p>facility after he/she was discharged from the hospital.</p> <p>A review of the facility elopement program policy documented that their elopement program assessed the resident for specific behaviors to identify elopement risk such as the resident frequency of wandering and/or experiencing hallucinations. Further review of the policy showed no directives for staff on how to mitigate the risk of resident elopement. Additionally, the facility's "Individual Protective Care and Watchful Oversight" policy showed that the facility would provide protective care and watchful oversight as outlined in the Negotiated Service Plan (NSP). Further review of the policy showed no procedures directing staff regarding watchful oversight.</p> <p>A review of the care plan for R1 dated 9/13/24, showed that R1 occasionally displayed bouts with confusion, and he/she had some difficulty recalling details and required occasional verbal prompting to assist with re-orientation.</p> <p>A review of the facility's progress notes showed staff documented that on 11/7/24, Resident #1 was up all night in his/her room, paced up and down the hallway, repetitively talked about his/her deceased spouse who he/she needed to talk to. Furthermore, staff documented in progress notes that the family member of Resident#1 had to come to the facility to sit with Resident #1 because staff were not able to simultaneously provide watchful oversight to Resident #1, while trying to provide care and services to the other residents in the facility.</p> <p>During an interview on 2/5/25, Staff C stated that R1 frequently wandered about the facility and hallucinated about a little girl and his/her deceased spouse.</p> <p>A review of an email received on 2/14/25 at 10:00 a.m. from Staff A hired 12/2024 indicated that when a resident was deemed an exit seeker, an immediate meeting with family would occur and family would need to find alternative placement into a memory care community for their loved one. Additionally, Staff</p>		

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{L 0937} SS= D	<p>A indicated that either a sitter would have to be hired to sit with Resident#1 and/or family would be responsible to be onsite with Resident #1 until Resident #1 could find an alternative living arrangement.</p> <p>In an interview Staff A stated that he/she could not answer if Resident#1 was an elopement risk. Staff A offered no explanation as to what safety measures the facility had put in place to provide watchful oversight for residents at risk of elopement.</p> <p>Cross reference TAG 0937 as it relates to the failure of the governing body to ensure to provide additional staff to meet the unique needs of the residents at risk of elopement.</p> <p>Cross reference TAG 2501 as it relates to the failure of the governing body to ensure that staff provided appropriate care and services in the form of protective care and watchful oversight to mitigate the risk of elopement.</p> <p>111-8-63-.09(18) Staffing. The community must maintain an average monthly minimum on-site staff to resident ratio of one awake direct care staff person per 15 residents during waking hours and one awake direct care staff person per 20 residents during non-waking hours where the residents have minimal care needs. Average monthly minimum staffing levels shall be calculated and documented by the community using methods and forms specified by the department. However, the assisted living community must staff above these minimum on-site staff ratios to meet the specific residents' ongoing health, safety and care needs.</p> <p>This REQUIREMENT is not met as evidenced by:</p>		

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	<p>>>>>Based on record review and interview, the community failed to ensure that they staffed above the minimum on-site staff ratios to meet the specific resident's ongoing health, safety and care needs for one resident (Resident#1). Findings include:</p> <p>According to the facility reported incident submitted to the Department on 11/17/24, showed documentation of a resident elopement involving Resident #1 (R1) which occurred on 11/17/24 during the early morning hours (third shift). The incident report detailed that R1 resided on the first floor of the assisted living section and staff determined that R1 went missing on 11/17/24 between the hours of 8:30 a.m., and 11:13 a.m. R1 was found in a vacant car located across the street from the facility, on a private residential property unharmed. Resident #1 was transferred to the hospital for further evaluation by ambulance and then relocated to a different long term care facility after he/she was discharged from the hospital.</p> <p>A review of an email received from Staff A on 2/14/25 at 10:00 a.m. reported, if a resident was deemed an exit seeker, an immediate meeting with family would occur and family would need to find alternative placement into a memory care community for their loved one. Additionally, Staff A indicated that either a sitter would have to be hired to sit with Resident#1 and/or family would be responsible to be onsite with Resident #1 until Resident #1 could find an alternative living arrangement</p> <p>A review of the facility's progress notes showed staff documentation dated 11/7/24, that Resident #1 was up all night in his/her room, paced up and down the hallways, repetitively talked about his/her deceased spouse who he/she needed to talk to. Furthermore, staff progress notes showed that the family member of Resident#1 had to come to the facility to sit with Resident #1 because staff were not able to simultaneously provide watchful oversight to Resident #1, while trying to provide care and services to the other residents in the</p>		

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	<p>facility.</p> <p>During an interview on 1/28/25 (12:17 p.m. to 3:00 p.m.), Staff B hired 7/2022 stated that Resident # 1 had been diagnosed with dementia, had a UTI, and was receiving home health services twice a week prior to the elopement on 11/17/24 (He/she was unable to provide the specific dates).</p> <p>During an interview on 1/28/25(12:17 p.m. to 3:00 p.m.), Staff C hired 8/2024 stated Staff that Resident #1 wandered the halls and hallucinated, often looking for his/her husband, a dog, and a little girl, prior to the elopement on 11/17/24 (He/she was unable to provide the specific dates).</p> <p>A review of the Physician's Progress notes dated 10/23/22 for Resident #1 showed a diagnoses of Late onset Alzheimer dementia.</p> <p>A review of Resident # 1's Care Plan dated 3/5/24 and 9/13/24 showed that he/she demonstrated occasional confusion, difficulty recalling detail and occasional prompting for orientation in the Cognitive/Psycho-social section. Additional review showed on the 9/13/24 care plan showed that he/she needed support to make appropriate decision and mild/moderate/severe memory loss.</p> <p>A review of the facility's schedules dated for the weeks of 11/10/24 to 11/16/24 and 11/17/24 to 11/23/24 showed a pattern of two staff scheduled 11:00 a.m. to 7:00 a.m.(third shift). A review of the facility records does not show that additional watchful oversight was provided to meet Resident #1's health and safety needs. Resident #1 resided on a non-memory care unit.</p> <p>During a facetime interview on 2/14/25 at 11:55 a.m. Resident#1 stated that he/she climbed out the window at his/her old facility and got into a car because he/she was going to New York.</p>		

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{L 2063} SS= D	<p>In an interview Staff A stated that he/she could not answer if Resident#1 was an elopement risk. Staff A offered no explanation as to what safety measures the facility had put in place to provide watchful oversight for Resident #1 who was at risk of elopement.</p> <p>Storage and Disposal of Medications. The assisted living community must ensure that it properly disposes of unused medications using the current U.S. Food and Drug Administration or U.S. Environmental Protection Agency guidelines for the specific medications. Authority O.C.G.A. §§ 31-2-7,31-2-8, and 31-7-1 et seq.</p> <p>This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure that it properly disposed of unused medications using the current U.S. Food and Drug Administration or U.S. Environmental Protection Agency guidelines for the specific medications. Findings include:</p> <p>During an interview on 2/5/25 at 12 p.m., Staff C stated that on 2/26/24 at 9 p.m., he/she accidentally dropped the medications Acetamin (muscle spasms), Duloxetine (depression) and Meloxicam (neuropathy) prescribed for Resident #5 onto the floor and then Staff C picked up the medications off the floor and administered them to Resident #5.</p> <p>A review of the facility's medication disposal policy did not address how staff should handle medications that had been dropped on the floor and possibly</p>		

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<p>{L 2501}</p> <p>SS= J</p>	<p>contaminated.</p> <p>During an interview on 2/5/25 at 12:00 p.m., Staff C stated that he/she was not aware that he/she should have disposed of the medication that had fallen onto the floor.</p> <p>111-8-63-.25(1)(a) Supporting Residents' Rights.</p> <p>The assisted living community must provide to each resident care and services which are adequate, appropriate, and in compliance with state law and regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>****>>>>Based on record review and interview, the facility failed to provide to each resident care and services which were adequate, appropriate, and in compliance with state law and regulations for one resident. (Resident #1).</p> <p>Findings include:</p> <p>A review of the facility reported incident submitted to the Department on 11/17/24, showed documentation of a resident elopement involving Resident #1 (R1) which occurred on 11/17/24. According to the incident report, R1 resided on the first floor of the assisted living section and staff determined that R1 went missing on 11/17/24 between the hours of 8:30 a.m. and 11:13 a.m. R1 was found in a vacant car located across the street from the facility, on a private residential property unharmed. Resident #1 was transferred to the hospital for</p>		

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	<p>further evaluation by ambulance and then relocated to a different long term care facility after he/she was discharged from the hospital.</p> <p>A review of the file for Resident #1 (R1) showed an admission date of 5/13/22. The physician's medical examination dated 5/12/22 showed diagnosis of: HTN, Chronic A-fib, Rt Bundle Branch Block, Encephalopathy, and Diaphragmatic Hernia. The care plan dated 9/13/24, showed R1 had occasional confusion, difficulty recalling details, and required occasional prompting or orientation. The care plan did not address how staff would support R1 and ensure appropriate decisions were made about his/her environment daily.</p> <p>During a tour of the facility on 2/5/25 at 3:30 p.m., Resident #1's apartment prior to the elopement incident was Room# 423 on the first floor of the assisted living unit. Resident #1's room was located at the end of the hall on the left side. The window Resident #1 exited from was located at the back of the building. There were no alarms or audible sensors on the windows or doors during the visit. To the left of the window was the facility parking lot, a road and private residences. To the right of the window, on the facility property, was a grassy area and a lake. The private residence where Resident #1 was found was enclosed by a black picket type fence. The entrance to the driveway was open. To the left of the residence upon entering onto the property was a shed structure. The vacant vehicle was in front of the shed structure.</p> <p>During a telephone interview on 2/6/25 at 11:10 a.m. Staff E hired 6/2024 stated that staff started searching the entire building and the outside of the building because they could not locate Resident #1. Staff E stated that he/she decided to go over to the neighboring private residences that were across the street from the facility. He/she stated that when he/she started walking towards the house, a car door opened, and it was Resident #1. Staff E notified Staff D. Once Staff D arrived, Staff E went back to the facility to retrieve Resident #1's bathrobe from his/her room because it was cold outside. Staff E stated</p>		

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	<p>that he/she did not remember times or what Resident #1 was wearing. Staff E stated that an unknown male at the private residence showed him/her a ring video. Staff E stated that you could hear someone screaming "help me, I need water" repeatedly. He/she said he/she could not see Resident #1 in the video, but he/she could hear him/her clearly. He/she stated that he/she believes that Resident #1 was hanging out of the window because he/she could hear something that sounded like window blinds hitting up against the window. He/she stated that the screams were recorded at 12 a.m. and around 2 a.m. based on the timestamp that he/she saw on the video. Staff E stated that another section of the video showed Resident #1 walking onto the property. He/she could not say what the time was because the person showing the video walked away to show it to others that were present. Staff E left after the EMT's, AA and the police arrived.</p> <p>A review of an emailed written statement from Staff A, dated 11/17/24 for AG1 showed that Agency staff 1 (AG1) went to Resident #1's room around 8:30 a.m. on 11/17/24. He/she wrote that Resident #1 was not present, so he/she went back to working on the medication cart. AG1 returned to Resident #1's room at 9:30 a.m. and he/she was still not in his/her room. AG1 alerted management and they started looking for Resident #1. When they could not locate Resident#1, the police were called.</p> <p>During a telephone interview on 2/6/25 at 10:53 a.m. Staff D hired 8/2019 stated that on 11/17/24 at approximately 10:45 a.m. he/she asked other staff if they had seen Resident #1. When he/she was told no, Staff D notified Staff F that Resident #1 was missing. Staff D stated they locked down the facility and conducted a search of the building and the grounds and could not locate Resident #1. Staff D stated he/she called 911. Staff D received a call within minutes that Resident #1 had been in a vacant car at one of the private residences. Staff D stated he/she advised Staff F and went to the private residence. Staff D stated that Resident #1 was wearing a pair of blue pants, a floral printed</p>		

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	<p>long-sleeved shirt and he/she thinks a pair of slippers or socks. Staff D stated that there was dirt on the knees of Resident #1's pants. He/she stated that Resident #1 was asking for water and his/her medication. Staff D stated that he/she did not see any injuries. Staff D stayed with Resident #1 until the EMT's, the police and AA arrived. Staff D stated that the day before (11/16/24) Resident #1 was experiencing some confusion.</p> <p>During a telephone interview on 2/13/25 at 8:11 a.m. Staff G hired 10/2024 stated that he/she worked the 3rd shift (11:00 p.m. to 7:00 a.m.) on 11/16/24. He/she stated that he/she arrived at work at 11:00 p.m. Staff G stated Resident #1 approached him/her within the first 15 minutes as he/she was wandering down the hall. Staff G redirected Resident #1 back to his/her room and he/she complied. Staff G stated that Resident #1 had poked his/her head out of the room a couple of times but did not exit. Staff G stated that he/she sat in the common area which was across from Resident #1's room. Staff G stated around 4:00 a.m., he/she heard some banging noises coming from Resident #1's room. Staff G stated that when he/she opened the door, Resident #1 was observed sitting in a chair, knitting a red blanket. Staff G stated that he/she asked when Resident #1 would be going to bed and he/she stated that Resident #1 said he/she would be going to bed later. Staff G stated that he/she started his/her rounds shortly after that. Staff G stated that he/she did not check on Resident #1 before leaving that day because he/she had already seen him/her several times that night. Staff G stated that Resident #1 appeared to be in a good mood that night. Staff G stated that because it was third shift, he/she would have heard any noise or screams because the building was quiet. Staff G stated that the doors were coded and had they been opened, an alarm would have gone off. Staff G stated that Resident #1's room was the last room on the left side. Staff G stated that he/she quit because he/she didn't like that he/she was questioned by management.</p> <p>During a telephone interview on 2/7/25 at 9:56 a.m. AA (the family member of</p>		

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	<p>Resident#1) stated that he/she visited Resident #1 on 11/16/24 around 8:30 p.m. at the facility because Resident#1 kept calling him/her. AA stated that he/she sat with Resident #1 until around 11:00 p.m. He/she stated that Resident #1 was calm when he/she left and said that he/she was going to go to bed. He/she stated that Resident #1 still had on his/her clothing from the day. AA stated on 11/17/24 around 11:00 a.m. he/she received a call from someone (unknown) from the facility asking if Resident #1 was there. He/she stated that he/she advised them that Resident #1 was not with them. He/she stated that he/she and the rest of the family went to the facility. By the time he/she arrived, Resident #1 had been located. He/she stated that Resident #1's clothing was muddy, and he/she had a few scrapes. AA stated that Resident #1 stayed in the hospital for 48 hours for dehydration and stayed an additional three days until AA could locate another facility. AA stated that when Resident #1 was admitted to the facility, he/she had already been diagnosed with early on-set dementia. He/she stated the facility had closed their memory care unit so Resident #1 was admitted into the assisted living community. AA stated that Resident #1 had been saying that he/she wanted to leave the facility for about six months, but he/she would change his/her mind frequently. AA stated that the facility staff advised him/her that Resident #1 had a UTI (urinary tract infection) and needed his/her prescription filled. AA stated that the prescription was not covered by insurance, and they could not pay \$600. AA stated that the pharmacy was able to get another prescription that was covered by Resident #1's insurance. AA stated that he/she administered the first dose and took the medication to the facility. AA stated a week prior to the elopement, he/she was supposed to meet with management at the facility about Resident #1, but he/she couldn't make the appointment. He/she stated that after the elopement, some unknown staff member called him/her to discuss moving Resident #1 to another one of their facilities. AA stated that he/she declined allowing Resident #1 to return to the facility due to his/her concern that the facility did not provide a secured unit and that the staff were unable to provide appropriate resident supervision and oversight for Resident#1 who had diagnosed issues with confusion and early on-set</p>		

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	<p>dementia.</p> <p>During a facetime interview on 2/14/25 at 11:55 a.m. Resident #1 stated that he/she climbed out the window at his/her old facility and got into a car because he/she was going to New York. Resident #1 was in bed during the interview.</p> <p>A review of the hospital discharge documentation dated 11/17/24 showed under “reason for your visit that Resident #1 arrived at the hospital after “wandering around all night”. Resident #1 eloped from the facility and was found in a neighbor’s yard. At the time of the hospital admission, Resident #1 reported that his/her neck was sore. After the elopement, the facility-initiated assistance in having Resident#1 transported to the hospital for further evaluation. The facility staff wanted Resident #1 assessed and the family member of Resident #1 was concerned that Resident #1 was dehydrated. Resident #1 was admitted to the hospital on 11/17/24 and discharged on 11/25/24. Resident #1 was diagnosed with the following conditions: Acute Encephalopathy(sudden alteration or disturbance of the brains function that leads to confusion or memory loss), AKI (Acute Kidney Injury), dementia, Hypoxia (a region of the body is deprived of adequate oxygenation at the tissue level) and Leukocytosis(an increase in the number of white blood cells in the blood which could indicate the body is attempting to fight an infection). The discharge diagnosis (11/25/24) listed on the discharge documentation showed: generalized weakness, Acute Encephalopathy with underlying dementia, AKI, dehydration (can lead to kidney failure, disorientation, seizures, coma and death-Mayoclinic.org), hypoxia (can cause shortness of breath and difficulty breathing-Mayoclinic.org), Leukocytosis, Chronic Debility and Dementia. R1 was discharged from the hospital eight (8) days later on 11/25/24 and relocated to a different long term care facility.</p> <p>A review of the website Chamblee, GA Weather History Weather Underground [https://www.wunderground.com/history/daily/KPDK/date/2024-11-17], the outdoor</p>		

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	temperatures ranged from 40 degrees Fahrenheit to 52 degrees Fahrenheit on 11/17/24, between the hours of 12:53 a.m. to 8:53 a.m.		