STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000720	A. BUILDING B. WING	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLEVUE VILLAGE AT WOODSTOCK	1000 PROFESSIONAL PKWY WOODSTOCK, GA 30188

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{0000}	Initial Comments. >>>> The purpose of this visit was to investigate intakes GA50004389, GA50004391, GA50004208, GA50004457 and GA50003338. The investigation began 7/31/25. An unannounced visit to the facility was conducted on 7/31/25, and the investigation concluded on 8/13/25.
{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: >>>> This RULE is not met as evidenced by: Based on record review and staff interviews, the assisted living community failed to provide to each resident care and services which are adequate, appropriate, and in compliance with state law and regulations for 1 of 1 resident (Resident #1). Findings Included:

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	A review of the facility's incident report revealed on 5/7/25, Resident #1 requested to go outside into the memory care unit's courtyard. Review of the incident report showed Staff C accompanied Resident #1 outdoors. The incident report showed Resident #1 asked for ice water. The report showed Staff C stepped indoors, asked Staff D to watch and went to retrieve the water. The report revealed Staff D passed Staff C within seconds, exited onto the outdoor patio and found Resident #1 face down on the ground bleeding from the forehead. The report further revealed Staff D observed Resident #1's wheelchair still upright and brakes locked. The report revealed 911 was called. The report revealed a pressure bandage was applied to Resident #1's forehead and Resident #1 was transported to a local hospital by EMS. A review of Resident #1's file showed a physician's medical evaluation with diagnoses: atherosclerosis, heart disease, dementia, diabetes and COPD. Physical limitations: wheelchair. Mental health limitations: dementia. Resident #1 receives hospice services. A review of Resident #1's death certificate showed Resident #1 died of pneumonia and Chronic Obstructive Pulmonary Disease (COPD). During an interview on 7/31/25, Staff A stated that after the incident Resident #1 was transported to a hospital, then to rehabilitation. Staff A stated that Resident #1 never returned to the facility. During an interview on 7/31/25, Staff C stated that he/she accompanied Resident #1 outdoors to the courtyard. Staff C stated Resident #1 requested water. Staff C stated that as he/she went inside to get water he/she simultaneously asked Staff D to monitor Resident #1 while retrieving the water. Staff C stated that during the seconds it took to enter the facility, and pass Staff D, Staff D

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	observed Resident #1 on the ground with a head injury. During a telephone interview on 8/5/25, Staff D stated regarding the incident, Resident #1 was escorted outdoors by Staff C and Resident #1's hospice nurse. Staff D stated that after several minutes the hospice nurse left, and Resident #1 was monitored solely by Staff C. Staff D stated that Staff C entered the courtyard door and asked Staff D to accompany Resident #1 while he/she got Resident #1 water. Staff D stated that he/she and Staff C passed each other and in a manner of second he/she observed Resident #1 lying face down bleeding from the forehead. Staff D stated that Resident #1's wheelchair was found in an upright position and locked. Staff D stated that he/she alerted the former executive director and 911. Staff D stated that he/she applied a bandage to Resident #1's forehead until EMS arrived and Resident #1 was conscious and speaking. Staff D stated that while awaiting EMS AA, Resident #1's responsible party arrived. Staff D stated that Resident #1 was transported to a local hospital.