STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000717	A. BUILDING B. WING	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLANDS SENIOR LIVING NORCROSS	680 HOLCOMB BRIDGE ROAD NORCROSS, GA 30071

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{L 0000}	Initial Comments. >>>> The purpose of this visit was to investigate intakes GA00251693, GA00251706, GA00251793, GA00251938, and GA00251449. The investigation began on 2/19/25 and was completed on 2/27/25.
{L 1000} SS= D	111-8-63-.10(1) Community Accountability. The records required by these rules and other records maintained in the normal course of the business of the community must be available for inspection and review by properly identified representatives of the Department. This REQUIREMENT is not met as evidenced by: >>>> Based on record review and interview the facility failed to make the records required by these rules, and other records maintained in the normal course of the business of the community available for inspection and review by properly identified representatives of the Department. Findings include: A review of an Incident submitted to the Department on 10/18/24, showed an allegation of quality of care/treatment (supervision). Resident #1 eloped from the facility undetected on 10/7/24 and return on 10/8/24 by Law Enforcement. A review of the facility's incident reports, showed no documented report of Resident #1 eloping from the facility on 10/7/24. During an interview on 2/19/24, Staff A stated that he/she could not provide an incident report regarding Resident #1's elopement on 10/7/24.

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	A review of the Law Enforcement (LE) report dated 10/8/24 showed that Resident #1 was located at a pharmacy attempting to refill a prescription, 10.4 miles away from the facility. Resident #1 was returned to the facility on 10/8/24 by LE. Additional review showed that EE assisted LE with locating Resident #1. A review of the Physician's Evaluation for Resident #1 dated 8/25/24, showed the following diagnoses and mental limitations: bipolar effective, manic psychosis, poor judgement, mood instability and impulsivity. Additional record review showed an admission date 6/21/24. Cross reference: 111-8-63-.17(1)
{L 1700} SS= J	111-8-63-.17(1) Services in the Community. The assisted living community must provide assisted living, including protective care and watchful oversight, which meets the needs of the residents it admits and retains. This REQUIREMENT is not met as evidenced by: ****>>> Based on observations, record reviews, and interviews the assisted living community failed to provide protective care and watchful oversight, which meets the needs of the residents it admits and retains for 2 of 2 sampled residents (Resident #1 and Resident #2). Findings include: A review of an Incident submitted to the Department on 10/18/24, showed an allegation of quality of care/treatment (protective care /watchful oversight). Resident #1 eloped from the facility undetected on 10/7/24 and return on 10/8/24 by Law Enforcement. An additional incident report submitted to the Department on

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	10/18/24 and 10/21/24 (self-reported), showed an allegation of quality of care/treatment (protective care/watchful oversight). Resident # 2 eloped from the facility undetected on 10/16/24 and return on 10/16/24 by Law Enforcement. A review of the Law Enforcement report dated 10/8/24 showed that Resident #1 was located at a pharmacy attempting to refill a prescription, 10.4 miles away from the facility. Additional review showed that EE assisted LE with locating Resident #1. A review of the Physician's Evaluation for Resident #1 dated 8/25/24, showed the following diagnoses and mental limitations: bipolar effective, manic psychosis, poor judgement, mood instability and impulsivity. Additional record review showed an admission date 6/21/24. A review of the initial care plan for Resident #1, dated 6/25/24 showed that Resident #1 was admitted from a psychiatric hospital with occasional difficulty with short term memory and long term memory. Additional review showed a history of wandering and needed protection and supervision for unsafe and inappropriate behavior. A review of the facility's Elopement/Missing Resident policy, showed the identified facility responsibility which is to ensure the safety and needs for those residents that leave the community without the knowledge of the community employees. Additional review showed that the facility would complete assessments, review measure to protect the resident and identify issues to eliminate recurrence. This policy did not show procedures in accordance to the Mattie's Call Act. A review of the facility's schedule (non-memory care unit - AL) for 10/7/24 showed four (4) scheduled staff working the 7:00 a.m. to 7:00 p.m. shift and three (3) scheduled staff working the 7:00 p.m. to 7:00 a.m.(this shift ended on

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	10/8/24). Additional review showed on 10/8/24 showed four (4) staff working the 7:00 a.m. to 7:00 p.m. shift and three (3) schedule staff working the 7:00 p.m. to 7:00 a.m.(this shift ended on 10/9/24). During an interview on 2/19/25, Staff A stated that Resident #1 eloped from the facility on 10/7/24 during the evening hours and was found on 10/8/24 at a pharmacy by law enforcement. Staff A stated that law enforcement was alerted on 10/8/24 by Staff B and Staff H. Staff A also stated that the eloped time frame was confirmed by EE, who was able to track Resident #1's locations. On 10/7/24 Resident #1 traveled to his/her previous residence (stayed overnight) and on 10/8/24 before being found, he/she traveled to a pharmacy. Resident #1eloped by accessing a car; he/she received a car key from Resident #6 (roommate). Resident #1 was able to exit the facility by entering the key codes to the facility's door. Staff A further stated that he/she was aware of Resident #1's diagnoses and mental health limitations. Resident #1 resided on the non -memory care unit. During an interview on 2/19/25, Staff B stated that Resident #1's roommate, Resident # 6, had access to a vehicle for errands. During an interview on 2/19/24, Staff C stated during morning med pass on 10/8/25 at around 8:00 a.m., Resident #6 advised him/her that Resident #1 was still asleep. Staff C stated that he/she returned to Resident #1's and Resident #6's room at about 8:30 a.m., when Resident #6 admitted that Resident #1 was not present and took his/her car keys to go home (previous residence). The facility called the law enforcement and EE on 10/8/24. Staff C further stated that he/she was unsure of the last time Resident #1 was seen. During an interview on 2/19/25, Resident #1 stated that he/she left out of the facility and drove home (previous residence). During an interview on 2/19/25, Resident #6 stated that Resident #1 took his/her

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	car keys and left the facility. Resident #1 wanted to go home (previous residence) to retrieve some items and he/she was gone overnight. During interviews on 2/19/25, Staff A, Staff C, and Staff I stated that they had no knowledge of when or how Resident #1 left the facility. A review of the facility's entity self-report submitted to the Department on 10/21/24 showed a reported elopement. Resident #2 eloped on 10/16/24 from the facility at approximately 7:20 p.m.; he/she was last seen around 5:30 p.m. on 10/16/24. The facility contacted the family to advise. Resident #2 was found by a stranger (homeowner) in the community on 10/16/24, eight tenth of a mile from the facility. The stranger (homeowner) contacted Law Enforcement (LE). Law Enforcement made contact with Resident #2 on 10/16/24 at 6:13 p.m.; he/she was return to the facility by law enforcement (no specific return time noted). A review of the facility's Elopement/Missing Resident policy, showed the identified facility responsibility which is to ensure the safety and needs for those residents that leave the community without the knowledge of the community employees. Additional review showed that the facility would complete assessments, review measure to protect the resident and identify issues to eliminate recurrence. This policy did not show procedures in accordance to the Mattie's Call Act. A review of the facility's record show no documentation that facility was aware Resident # 2 had eloped from the facility; no Mattie Call initiative nor law enforcement contact documented for 10/16/24 . A review of the Physician's Medical Evaluation for Resident 2#'s dated 9/5/24, showed the following diagnoses and mental health limitation: dementia, anxiety, arthritis, hearing loss, anemia, and hypertension. Additional review showed

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	required assistance due to wandering and risk of leaving the building. Resident was admitted on 9/25/24 and resided on the non-memory care unit. A review of the facility's schedule (non-memory care unit - AL) for 10/16/24 showed four (4) scheduled staff working the 7:00 a.m. to 7:00 p.m. shift and three (3) scheduled staff working the 7:00 p.m. to 7:00 a.m.(this shift ended on 10/17/24) During an interview on 2/19/25, Staff A stated on 10/16/24 Resident #2 eloped and wandered to a stranger's home and the homeowner called LE. Staff A stated that Resident #2 was returned to the facility that evening on 10/16/24. Staff A stated that Resident #2 sustained no injuries. Staff A stated that he/she was unsure which LE agency returned Resident #2. Staff A stated that that there were some high school volunteers in the facility that night and perhaps Resident #2 manage to elope through the front door when the youth exited. During an interview on 2/19/25, Resident #2 stated that he/she did not recall the incident. A review of the facility records does not show that watchful oversight/supervision was provided to both Resident #1 and Resident #2 by the facility. During a tour of the facility on 2/19/25 the rooms of Resident #1 and Resident #2 were located on the 2nd floor. The facility's side doors and the front entrance doors were armed with a keypad was observed. Further observation showed no internal or external cameras except for the front doorbell camera. Census 66

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{L 3001} SS= D	111-8-63-.30(2) Reports to the Department. Whenever a serious incident involving a residents occurs, the assisted living community must report in a format acceptable to the Department either within 24 hours after the incident has occurred, or the assisted living community has reasonable cause to believe that a reportable incident involving a resident has occurred . This REQUIREMENT is not met as evidenced by: >>>> Based on record review and interview the facility failed to report in a format acceptable to the Department either within 24 hours after the incident has occurred, or the assisted living community has reasonable cause to believe that a reportable incident involving a resident has occurred for 2 of 2 sampled residents (Resident #1 and Resident #2). Findings include: A review of an Incident submitted to the Department on 10/18/24, showed an allegation of quality of care/treatment (protective care /watchful oversight). Resident #1 eloped from the facility undetected on 10/7/24 and return on 10/8/24 by Law Enforcement. An additional incident report submitted to the Department on 10/18/24 and 10/21/24 (self-reported), showed an allegation of quality of care/treatment (protective care/watchful oversight). Resident # 2 eloped from the facility undetected on 10/16/24 and return on 10/16/24 by Law Enforcement. During an interview on 2/19/24, Staff A stated that he/she could not provide an incident report regarding Resident #1's (10/7/24) and Resident # 2 (10/16/24) elopements. He/she could not explain why the elopement incidents was not reported within 24 hours after the incident occurred. A review of the facility's report to the Department showed no self-entity report for Resident # 1 elopement on 10/7/24 and returned to the facility on 10/8/24.

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	Further review show that Resident #2 elopement occurred on 10/16/24 and returned to the facility on 10/16/24; the Department received the self-entity report on 10/21/24. The Department should have received Resident # 1's self-reported incident on 10/9/24 and Resident #2' self-reported incident on 10/17/24. A review of the Physician's Evaluation for Resident #1 dated 8/25/24, showed the following diagnoses and mental limitations: bipolar effective, manic psychosis, poor judgement, mood instability and impulsivity. Additional record review showed an admission date 6/21/24. A review of the Physician's Medical Evaluation for Resident 2#'s dated 9/5/24, showed the following diagnoses and mental health limitation: dementia, anxiety, arthritis, hearing loss, anemia, and hypertension. Additional review showed required assistance due to wondering and risk of leaving the building. Resident was admitted on 9/25/24. Cross reference: 111-8-63-.17(1)