STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000303	A. BUILDING B. WING	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westhill of Macon	**111 PROVIDENCE BLVD MACON, GA 31210**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{2003} SS= D	111-8-63-.20(2)(a)1-6. Assistance with Self Administration. [Staff assistance with or supervision of self-administered medications] may include only the following tasks: 1. taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing the medication to the resident; 2. reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container, in the presence of the resident; 3. placing an oral dosage in the resident's hand or placing the dosage in another container where the resident requests assistance; 4. applying topical medications; 5. returning the medication container to proper secured storage; and 6. assisting the resident's use of an EPI pen where the resident has known severe allergies for which an EPI pen has been prescribed on condition that there is an established written protocol detailing how it is to be used and when. The protocol must include immediately calling Emergency Services, 911, after any use of the EPI pen. This REQUIREMENT is not met as evidenced by: >>>>Based on observation, record review and interviews, the facility failed to ensure staff providing medication assistance with or supervision of self-administered medications include only the following tasks: 1. taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing the medication to the resident; 2. reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container, in the presence of the resident; 3. placing an oral dosage in the resident's hand or placing the dosage in another container where the resident requests assistance; 4. applying topical medications; 5. returning the medication container to proper secured storage; and 6. assisting the resident's use of an EPI pen where the resident has known severe allergies for which an EPI pen has been prescribed on condition that there is an established written protocol detailing how it is to be used and when. The protocol must include immediately calling Emergency Services, 911,

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	after any use of the EPI pen. Findings include: A review of the medication assistance record (MAR) for Resident #1 showed Armodafinil tab 150 mg was to be taken by mouth once daily for 10 days starting 3/12/25 until 3/21/25 at 8:00 a.m. A review of the March 2025 controlled drug receipt/record disposition form for Resident #1 showed the following: Resident #1 was given Armodafinil tab 150 mg on 3/12/25 at 12 a.m. (9 were left), 3/12/25 at 8 a.m. (8 were left), 3/13/25 at 6:00 a.m. (7 were left), and 3/13/25 at 8:00 a.m. (6 were left) 3/14/25 at 1:00 am (5 were left) 3/14/25 8:00 a.m. (4 were left). During an interview on 5/7/25 at 11:45 a.m., Staff D acknowledged that the medication was administered inappropriately.
{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.

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This REQUIREMENT is not met as evidenced by:
>>>>Based on observations, record reviews and interviews, the facility failed to ensure staff must provide to each resident care and services which are adequate, appropriate, and in compliance with state law and regulations.
Findings include:

A review of the controlled drug receipt/record disposition form for March for Resident #1 showed the following: Resident #1 was given Armodafinil tab 150 mg on 3/12 at 12 a.m. (9 were left), 3/12/25 at 8 a.m. (8 were left), 3/13 at 6:00 a.m. (7 were left), and 3/13 at 8:00 a.m. (6 were left) 3/14 at 1:00 am (5 were left) 3/14 8:00 a.m. (4 were left). The directions on the form stated the Armodafinil was to be taken once daily by mouth for 10 days.

A review of the facility incident report for Resident #1 dated 3/14/25 showed Resident #1 was given a control substance Armodafinil 150 mg as a PRN (as needed) when the medication assistance record and pill bottled showed the medication was supposed to be given once a day at 8:00 a.m.

A review of the emergency room report showed Resident #1 was treated and released for accidental drug poisoning.

During an interview on 5/7/25 at 11:45 a.m., Staff D acknowledged the medication was administered inappropriately.

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{L 0000}	Initial Comments. >>>>The purpose of this visit was to conduct a compliance inspection and investigate intake #GA50002293. An unannounced visit was made to the facility on 5/7/25 and was completed on 5/9/25.
{L 2010} SS= D	111-8-63-.20(3) Community Administration of Medications. Community Administration of Medications. Where the residents either are not capable of self-administration of medications or choose not to self-administer medications with assistance or supervision, the assisted living community must provide medication administration services to the residents in accordance with physicians' orders, the needs of the residents and these rules. This REQUIREMENT is not met as evidenced by: >>>>Based on record reviews and interviews, the facility failed to provide medication administration services to the residents in accordance with physician's orders, the needs of the residents and these rules for one of three sampled residents (Resident #1). Findings include: A review of the the March 2025 medication assistance record (MAR) for Resident #1 showed Armodafinil tab 150 mg was to be taken by mouth once daily for 10 days starting on 3/12/25-3/21/25 at 8:00 a.m. A review of the March 2025 controlled drug receipt/record disposition form for Resident #1 showed the following: Resident #1 was given Armodafinil tab 150 mg on 3/12 at 12 a.m. (9 were left), 3/12/25 at 8 a.m. (8 were left), 3/13 at 6:00

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	a.m. (7 were left), and 3/13 at 8:00 a.m. (6 were left) 3/14 at 1:00 am (5 were left) 3/14 8:00 a.m. (4 were left). The directions on the form stated the Armodafinil was to be taken once daily by mouth for 10 days. During an interview on 5/7/25 at 11:45 a.m., Staff D acknowledged the medication was administered inappropriately.