STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	016030031	A. BUILDING B. WING	06/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITES AT WILLOW POND (THE)	4344 COUNTRY CLUB ROAD STATESBORO, GA 30458

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{A 000}	Opening Comments. >>>>The purpose of this visit was to investigate self reported incident GA00175698. An on-site visit was made on 6/5/17 and the investigation was completed on 6/14/17.
{A 2604} SS= J	111-8-62-.26(2)(c) Procedures for Change in Resident Condition. Where the sudden change in the resident ' s condition causes the resident to experience cardiac or respiratory arrest, the home must immediately take one of the following actions: ... (c) If the resident has appointed a health care agent in a living will, durable power of attorney for health care or an advance directive for health care which complies with the requirements of O.C.G.A. §31-32-1 et seq. then the home must immediately contact the health care agent for directions regarding the care to be provided. Where the health care agent is not immediately available and there is no valid DNR order for the resident, the home must initiate cardiopulmonary resuscitation immediately and contact emergency medical services to arrange for emergency transport. This REQUIREMENT is not met as evidenced by: ****>>>>Based of record review and interview the facility failed to ensure when the sudden change in the resident's condition causes the resident to experience cardiac or respiratory arrest, to immediately initiate cardiopulmonary resuscitation (CPR) for a resident who was in respiratory distress for 1 of 1 sampled resident (Resident #1). Findings include: A review of a facility incident report dated 5/25/17 at 5:00 p.m., showed Resident #1 was at the dining room table and he/she became unresponsive. Staff called 911 and Resident #1 was transported to a local hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	016030031	A. BUILDING B. WING	06/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITES AT WILLOW POND (THE)	4344 COUNTRY CLUB ROAD STATESBORO, GA 30458

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	A review of the ambulance report showed the 911 call was received on 5/25/17 at 5:02 p.m. and the ambulance crew arrived at the facility at 5:09 p.m. Emergency Medical Services crew found Resident #1 slumped over in a wheelchair, with no pulse and Resident #1 was not breathing. There was no DNR order for Resident #1 and the crew began Cardiopulmonary Resuscitation (CPR). Resident #1 was transferred to the hospital. A review of hospital records showed Resident #1 arrived at the hospital at 5:42 p.m. Resident #1 was in cardiac arrest. Resident #1 passed away on 5/25/17 and he/she was released to the funeral home at 7:34 p.m. During an interview on 6/5/17 at 10:00 a.m., Staff B stated that when he/she walked into Memory Care Unit Resident #1 was slumped over a wheelchair breathing but not easily. The staff took Resident #1 to his/her room while Staff B left to call 911 and the family. Staff B stated that when he/she returned to the room, Resident #1 was breathing. Staff B stated that he/she left to look for Advance Directives; there was no DNR order. When Staff B returned to the room and told EMS there was no DNR order. The EMS crew initiated a CPR. During a telephone interview 6/6/17 at 2:00 p.m. Staff D stated that he/she was working in the personal care home unit when he/she received a call to go to the memory care unit. Staff D stated that he/she found Resident #1 in a wheelchair, drooling and with eyes closed. Resident #1 had a pulse at that time. When EMS arrived they asked if there was a DNR order. Staff B had to leave the unit to see if there was a DNR order. Staff B returned and said there was no DNR order. EMS crew then took Resident #1 out of the wheelchair, put him/her on the stretcher and began CPR. Staff D stated the facility staff did not take Resident #1 out of the wheel chair because they were afraid of hurting the resident. Staff D stated that he/she called the responsible party to report the EMS had arrived. The responsible party told Staff D he/she wanted everything possible done to revive Resident #1. During a telephone interview 6/7/17 at 3:00 p.m., one of the EMS crew stated that when he/she arrived at the facility, Resident #1 was slumped over in a wheel chair, not breathing and no pulse. Another crew member stated there were 3 staff just standing by Resident #1. Another crew member stated he/she asked if there was a DNR order for Resident #1, thinking there must be one if the staff was not doing CPR. Staff B left the area and returned some time later to report there was no DNR order. EMS crew initiated CPR and transported Resident #1 to the hospital. During a telephone interview on 6/8/17 at 4:15 p.m., Staff C stated that he/she was at the sink and Resident #1 was at the dining room table. Staff C stated that he/she turned around and saw

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	016030031	A. BUILDING B. WING	06/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUITES AT WILLOW POND (THE)	4344 COUNTRY CLUB ROAD STATESBORO, GA 30458

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	Resident #1's head was flopped back and eyes were rolled back. Staff C stated that he/she called for help and he/she and Staff E took Resident #1 to his/her room. Staff C stated that he/she pounded on Resident #1's back twice, fearing there might be something lodged in his/her throat. Staff C stated that nothing came out but Resident #1 did take 2 deep breaths. Staff C stated that he/she did not lay Resident #1 on the floor to do CPR because he/she thought Resident #1 might have something caught in his/her throat. Staff C stated that Resident #1 had no pulse and did not take any more breaths other than those two breaths. A review of the file for Resident #1 showed he/she was admitted to the memory care unit on 4/24/15 with diagnoses of Dementia, Depression, Anxiety, Rib Fracture, Dyslipidemia and Hypertension. Resident #1 also needed supervision with all Activities of Daily Living.