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	PCH009912	A. BUILDING B. WING	08/27/2021

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BOUNTIFUL HILLS	200 BOLTON DRIVE COMMERCE, GA 30529

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{A 000}	Opening Comments. The purpose of this visit was to conduct a compliance inspection and investigate # GA00214131, GA00215122, GA00215110, and GA00215245. The investigation started on 5/27/2021 and was completed on 8/27/2021
{A 0720} SS= D	111-8-62-.07(4) Governing Body. The governing body must not permit any person who is a member of the governing body, administration or staff to serve as the representative of a resident of the home. This REQUIREMENT is not met as evidenced by: >>>> Based on record review and interviews, the facility failed to ensure that governing body must not permit any person who is a member of the governing body, administration or staff to serve as the representative of a resident of the home for sampled 1of 14 sampled residents (Resident #10). Findings include: A review of the hospice file for Resident #10 on 8/29/2019 showed a plan of care and hospice preferences. CPR discussion On 8/28/19, Resident #10 was asked did he/she want CPR if the heart and lungs stopped working, and the resident stated no. Other Life-Substantiating treatment preferences-(HISF2100A)

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	A. Resident #10/ responsible party was asked about preferences regarding life-sustaining life treatments other than CPR1 Resident #10 stated yes. Other Life Sustaining treatment Discussion Resident #10 responsible party was asked about preferences regarding life-sustaining life treatments other than CPR (HIS-F 2100 B): Resident #10 stated that he/she did want other life sustaining treatments and the type of treatment was antibiotics. Staff A and Resident #10 were involved and agreed with the hospice plan of care 8/28/2019. A review of the hospice notes on 8/28/2019 showed that Staff A was the primary care giver for Resident #1, and the administrator for the facility, and was working on becoming the resident (POA) power of attorney. On 8/29/2019, Resident #10 declined to sign the DNR and stated that he/she wanted CPR performed if he/she had a medical emergency. A review of the hospice visit note addendum on 8/28/2019 showed II and Staff A discussed that the resident was a full code and that Staff A was working on getting a DNR. Staff A was also working funeral arrangements because the finances were tight. A review of the hospice visit note addendum on 8/28/2019 showed II and Staff A discussed that the resident was a full code and that Staff A was working on getting a DNR. Staff A was also working funeral arrangements because the finances were tight.Furthermore, the hopice notes showed that Resident #1 did not want to be intubated or want any feeding tubes to sustain life, and the resident wanted to be cremated. On 10/18/2019, the hospice notes showed that Staff A, who acted as next of kin was unavailable to discuss final arraignments with JJ. On 12/3/2019, JJ discussed final arrangements for the resident with representative, Staff A. Staff A provided information for final arrangements and the information was added to the resident medical records. JJ discussed with Staff A whether the needs of the resident were beyond what the facility could manage and Staff A stated they were not. Staff A told JJ that he/she has applied for and submitted a waiver to the state will allow the facility to continue to provide care. On 2/3/2020, the hospice notes showed that JJ spoke with Resident #10 about code status and Staff A and Staff C also spoke with the resident about code status, and afterwards, the resident did not wish for chest compressions of intubation to take place in the event that his/her heart stop beating. The DNR orders and POLST were on file. A review of the file for Resident # 10 showed on 1/29/2020 that Staff A signed as the patient or authorized person signature on the physician orders for life-sustaining treatment (POLST). The form showed no signature for Resident # 10. A check was marked in box next to the following: Allow Natural Death (AND) -Do not attempt Resuscitation. A review of the funeral statement showed that Staff A paid for the services on 2/11/20 via debit card. Staff A signed as having the legal right to arrange final services for the deceased and have

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authorized funeral establishment to perform services, furnish goods, and incur charges on the statement.

A review of the file for Resident #10 showed diagnoses of dementia, hyperlipidemia, Parkinson's disease, and major depression.

A review of email sent from BB on 6/20/2021 at 7:46 a.m. showed that Resident #10 was lethargic, BB stated that Staff C was walking towards the room of Resident #10, 309B, with some papers in his/her hand. BB stated that he/she asked Staff C what she was doing, and Staff C stated that he/she was going to see if Resident #10 will give him/her and Staff A power of attorney (POA) since the resident did not have one. Staff C also stated that Resident #10 needed to sign a DNR because his/her health was declining since returning from the hospital. BB stated to Staff C that Resident #10 was lethargic and was not even speaking, let alone, able enough to consent to anything. Approximately 30 minutes later, BB had seen Staff C come to the front of the building to the office of Staff A. BB heard Staff C tell Staff A that he/she got Resident to sign.

During an interview on 6/24/2021 at 10:10 a.m., KK stated that Resident #10 told him/her that he/she signed a document to allow Staff A to control his/her finances which was a mistake.

During an interview on 8/27/2021 at 12:46 p.m., Staff A acknowledge the findings.

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{A 1009} SS= D	111-8-62-.10(6)(a) Staffing. Sufficient staff time must be provided by the home such that each resident: (a) Receives treatments, medications and diet as prescribed. This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to provide sufficient staff time to each resident: (a) receives treatments for 2 of 14 sampled residents. (Resident #2 and Resident #6). Finding include: A review of the file for Resident #2, admitted 5/17/2021, showed diagnoses of (GI) gastrointestinal bleed, dysphagia, diabetes, asbestos exposure pulmonary disease, and anxiety. On 5/17/2021, the progress notes for the resident showed that he/she moved from a hospital to the facility and was bed bound. A review of the physician's medical evaluation dated 5/11/2021, for Resident #2 showed he/she needed total help with transferring. A review of the resident census showed that two residents were incapable of self-preservation and 10 residents were wheel chair dependent. Resident #2 and Resident # 6 were bedbound. Eight residents were incontinent. During an interview on 6/30/2021 at 6:23 p.m., LL stated that the facility did not have two staff to take care of the residents in the memory care. LL stated that some residents would page staff while staff were changing a resident. LL stated that Resident #2 was bedbound, and Resident # 6 did not get out of bed. During an interview on 6//29/2021, GG stated that he/she visited Resident # 2 on 6/18/2021 and put resident on a new brief and dated the brief for 6/18/2021. GG stated that he/she visited the resident on 6/21/2021, and the resident had on the same brief with dried feces.

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	During an interview on 8/27/2021 at 12:46 p.m., Staff A stated acknowledged the findings.
{A 1314} SS= D	111-8-62-.13(6) Physical Plant Health and Safety Standards. Floors, walls, and ceilings must be kept clean and in good repair. This REQUIREMENT is not met as evidenced by: >>>>Based on observation and interview, the facility failed to kept the ceiling in good repair. Findings include: During a tour of the facility on 6/10/2021 at 8:43 a.m., crackle and peeling paint was observed on the ceiling in the memory care unit. Laminate flooring was buckling up in the hallway of the memory care unit. During an interview on 6/24/2021 at 10:10 a.m., KK stated during the time October 2020 and beyond, the ceiling had leaks and rain would fall into the memory care unit of the facility. KK stated that Staff A told staff to get towels and sheets to remove the water from the floor, October 2020. KK stated the laminate flooring was buckling up. During an interview on 7/1/2021 at 10:10 a.m., MM stated that tile and paint were peeling in the memory care unit.

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	During an interview on 8/27/2021 at 12:46 p.m., Staff A will work on the getting the floor fixed.
{A 1507} SS= D	111-8-62-.15(2) Admission. No home is permitted to admit or retain a resident who needs care beyond which the home is permitted to provide. This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interviews, the facility failed to comply with the regulation that prohibits a facility from retaining residents who required care beyond which the facility was permitted to provide for 1 of 14 sampled residents (Resident # 2 and Resiiddent #6) Findings include: A review of the file for Resident #2, admitted 5/17/2021, showed diagnoses of (GI) gastrointestinal bleed, dysphagia, diabetes, asbestos exposure pulmonary disease, and anxiety. On 5/17/2021, the progress notes for the resident showed that he/she was moved from a hospital to facility and was bed bound. A review of the physican's medical evaluation dated 5/11/2021, for Resident #2 showed he/she needed total help with transferring. During an interview on 6/11/2021 at 2:25 p.m., Resident #2 stated that he/she cannot get out of the bed. During an interview on 6/14/2021 at 1:58 p.m., AA stated that Resident #2 was bedbound. AA stated the resident required a two person assist, and staff rotated Resident #2 in the bed. AA stated that staff provided urinary and bowel incontinence care for the resident in the bed. AA stated that Resident #6 was beddound. During an interview on 6/16/2021 at 7:11 p.m., DD stated that Resident # 2 was bed bound. During an interview on 8/27/2021 at 12:46 p.m., Staff A stated that Resident # 2 was no longer at the facility. Staff A stated #6 has been getting out of the bed since that time in June 2021.

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{A 1930} SS= D	111-8-62-.19(5)(c) Addl Req(s) for Spec Memory Care Units/Homes. The home must ensure that the contained unit is staffed at all times with sufficient specially trained staff to meet the unique needs of the residents in the unit, including the following: ... (c) Staff who, prior to caring for residents independently, have successfully completed an orientation program that includes at least the following components in addition to the general training required in Rule 111-8-62-.09: 1. The home's philosophy related to the care of residents with dementia in the unit.

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2. The home's policies and procedures related to care in the unit and the staff's particular responsibilities including wandering and egress control.

3. An introduction to common behavior problems characteristic of residents residing in the unit and appropriate behavior management techniques.

This REQUIREMENT is not met as evidenced by:

>>>> Based on record review and interviews, the facility failed to ensure that the contained unit was staffed at all times with sufficient specially trained (orientation) staff to meet the unique needs of the residents in the unit for 2 of 11 sampled staff (Staff D and Staff F). Findings include:

A review of the file for Staff D, hired 6/11/2020, showed no orientation documentation of home's philosophy related to the care of residents with dementia in the unit, home's policies and procedures related to care in the unit and the staff's particular responsibilities including wandering and egress control, and introduction to common behavior problems characteristic of residents residing in the unit and appropriate behavior management techniques.

A review of the file for Staff F, hired 4/28/2020, showed no orientation documentation of home's philosophy related to the care of residents with dementia in the unit, home's policies and procedures related to care in the unit and the staff's particular responsibilities including wandering and egress control, and introduction to common behavior problems characteristic of residents residing in the unit and appropriate behavior management techniques.

A review of the time card for Staff D and Staff F showed on 5/29/2021 that the staff from 7:00 a.m. to 7:00 p.m.

A review of the time card for Staff D showed on 5/30/2021 that the staff from 7:00 a.m. to 7:00 p.m.

A review of the memory care facility 24 hour report sheet showed on 5/30/2021 that Staff D worked in the unit from 7:00 a.m. to 7:00 p.m.

A review of the time card for Staff D showed on 5/30/2021 that the staff from 7:00 a.m. to 7:00 p.m.

During an interview on 7/1/2021, Staff D stated that he/she worked in the memory care unit.

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	During an interview on 7/1/2021 at 10:15 a.m., MM stated that Staff D was worked in the memory care unit this week. During an interview on 8/27/2021 at 12:46 p.m., Staff A stated that Staff D has not been working at the facility and Staff F has been fully trained.
{A 1934} SS= D	111-8-62-.19(6) Addl Req(s) for Spec Memory Care Units/Homes. Initial Staff Training. Within the first six months of employment, staff assigned to the unit must receive training in the following topics: (a) The nature of Alzheimer's Disease and other dementias, including the definition of dementia, the need for careful diagnosis and knowledge of the stages of Alzheimer's Disease. (b) Common behavior problems and appropriate behavior management techniques. (c) Communication skills that facilitate better resident-staff relations. (d) Positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills. (e) The role of the family in caring for residents with dementia, as well as the support needed by the family of these residents. (f) Environmental modifications that can avoid problematic behavior and create a more therapeutic environment. (g) Development of comprehensive and individual service plans and how to update or provide relevant information for updating and implementing them consistently across all shifts, including establishing a baseline and concrete treatment goals and outcomes. (h) New developments in diagnosis and therapy that impact the approach to caring for the residents in the special unit. (i) Recognizing physical or cognitive changes in the resident that warrant seeking medical attention. (k) Maintaining the safety of residents with dementia.

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This REQUIREMENT is not met as evidenced by:

>>>> Based on record review and interview, the facility failed to provide initial staff training within the first six months of employment, staff assigned to the unit must receive training in the following topics for 2 of 11 sampled staff. Findings include:

During an interview on 6/14/2021, AA stated that Staff D worked in the memory care unit during the May 2021.

During an interview on 6/15/2021, Staff J stated that Staff D worked in the memory care unit this week.

During an interview on 6/16/2021 at 7:11 p.m., DD stated that Staff D worked in the memory care unit this week, 6/6/2021 through 6/12/2021.

During an interview on 6/29/2021 at 6:15 p.m., LL stated that Staff D worked in the memory care unit.

During an interview on 7/1/2021, Staff D stated that he/she worked in the memory care unit.

During an interview on 7/1/2021 at 10:15 a.m., MM stated that Staff D was worked in the memory care unit this week.

A review of the file for Staff D, hired 6/11/2020, showed no documentation of positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills, the role of the family in caring for residents with dementia, as well as the support needed by the family of these residents, environmental modifications that can avoid problematic behavior and create a more therapeutic environment, development of comprehensive and individual service plans, and new developments in diagnosis and therapy trainings.

A review of the file for Staff F, hired 4/28/2020, showed no documentation of behavior management skills, communication skills, positive therapeutic interventions and activities such as exercise, the role of the family in caring for residents with dementia, as well as the support needed by the family of these residents, environmental modifications that can avoid problematic behavior and create a more therapeutic environment, development of comprehensive and individual service plans, and new developments in diagnosis and therapy trainings.

A review of the facility staff schedule for the memory care unit showed that Staff D worked the

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following:

5/30/2021, 7:00 a.m. to 7:00 p.m.
5/16/2021, 7:00 p.m. to 7:00 a.m.
5/11/2021, 7:00 p.m. to 7:00 a.m.
5/10/2021, 7:00 p.m. to 7:00 a.m.
5/06/2021, 7:00 p.m. to 7:00 a.m.
5/02/2021, 7:00 p.m. to 7:00 a.m.

A review of the facility staff schedule for the memory care unit showed that Staff F worked the following:

5/30/2021, 7:00 a.m. to 7:00 p.m.
5/9/2021, 7:00 a.m. to 7:00 p.m.
5/08/2021, 7:00 a.m. to 7:00 p.m.
5/02/2021, 7:00 p.m. to 7:00 a.m

A review of an email sent on 6/10/2021 at 12:48 p.m. from Staff A showed that Staff D has failed to comply with the completion of the mandatory dementia training. In response to the staff failure to comply and complete all necessary training, this staff was given a written write-up (final) and has been pulled from our memory care unit until said training has been completed.

A review of an email sent on 6/22/2021 at 1:34 p.m. from Staff A showed that prior to the investigation, Staff F only went to the memory care when staff would ask him/her to assist them.

During an interview on 8/24/2021, Staff A stated that Staff D was no longer working in the facility and Staff F has been fully trained.

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{A 2025} SS= D	111-8-62-.20(5)(e) Medications. Refills of prescribed medications must be obtained timely so that there is no interruption in the routine dosing. Where the home is provided with a new medication for the resident, the MAR must be modified to reflect the addition of the new medication within 48 hours or sooner if the prescribing physician, advance practice registered nurse or physician assistant indicates that the medication change must be made immediately. In homes, where unit or multi-dose packaging is not available for immediate changes in medications, unit or multi-dose packaging of the medication must be obtained when the prescription is refilled. This REQUIREMENT is not met as evidenced by: >>>>Based on observation and interviews, the facility failed to obtain refills timely to prevent an interruption in the routine dosing of medications for 2 of 8 residents sampled (Resident #2 and Resident #3). Findings include: During an observation of the medication cart on 6/11/2021 at 3:27 p.m., GNP B-1 100 mg tabs, melatonin 3 mg tabs, simvastatin 40 mg tabs prescribed for Resident #2 were not in the cart. During an interview on 6/11/2021 at 3:25 p.m., Staff E stated that GNP B-1 100 mg tabs, melatonin 3 mg tabs, simvastatin 40 mg tabs were not in the medication cart that belong to Resident #2. A review of the (MAR) medication administration record for Resident #1 showed the prescribed medications were not in facility on the following:

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	Albuterol 0.5.-3 MG/3 5/9/2021 5/10/2021 Lidocaine 5% OINT, prescribed to apply two times a day to affect area 5/20/2021 5/24/201 5/26/2021 MG217 Psoriasis medicated, prescribed to massage into scalp and leave minutes then rinse, use daily 5/4/2021 5/5/2021 5/6/2021 5/7/2021 5/8/2021 5/9/2021 5/10/2021 5/11/2021 5/12/2021 5/14/2021 5/16/2021 5/17/2021 5/18/2021 5/20/2021 5/21/2021 5/23/2021 5/28/2021 5/29/2021 5/31/2021

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	A review of the (MAR) medication administration record for Resident #2 showed the prescribed medications were not in facility on the following: Melatonin 3 mg tabs, prescribed to two tablets by mouth nightly 5/26/2021 5/27/2021 5/29/2021 5/31/2021 Carvedilol 6.25 mg tabs, prescribed to take one tablet by mouth twice daily 5/26/2021 5/27/2021 Simvastatin 40 mg tabs, prescribed to one tablet by mouth at bedtime 5/26/2021 Spironolactone 25 mg tabs, prescribed to tablet by mouth everyday 5/26/2021 During an interview on 8/27/2021 at 12:46 p.m., Staff A stated that he/she was aware refills must be obtained in a timely manner, and staff will receive training today.
{A 2507} SS= D	111-8-62-.25(1)(c)4. Supporting Residents' Rights. Each resident must have the right to: ... 4. Make choices about aspects of his or her life in the home that are significant to the resident.

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This REQUIREMENT is not met as evidenced by:

>>>>Based on record review and interview, the facility failed to ensure each resident make choices about aspects of his or her life in the home that are significant to the resident. for 1 of 14 sampled residents (Resident #10). Findings include

A review of the hospice notes on 8/28/2019 showed that Staff A was the primary care giver for Resident #1, and the administrator for the facility, and was working on becoming the resident (POA) power of attorney. On 8/29/2019, Resident #10 declined to sign the DNR and stated that he/she wanted CPR performed if he/she had a medical emergency. Furthermore, the hopice notes showed that Resident #1 did not want to be intubated or want any feeding tubes to sustain life, and the resident wanted to be cremated. On 12/3/2019, JJ discussed final arrangements for the resident with representative, Staff A. Staff A provided information for final arrangements and the information was added to the resident medical records. On 2/3/2020, the hospice notes showed that JJ spoke with Resident #10 about code status and Staff A and Staff C also spoke with the resident about code status, and afterwards, the resident did not wish for chest compressions of intubation to take place in the event that his/her heart stop beating.

A review of the file for Resident # 10 showed on 1/29/2020 that Staff A signed as the patient or authorized person signature on the physician orders for life-sustaining treatment (POLST). The form showed no signature for Resident # 10.

A check was marked in box next to the following:

Allow Natural Death (AND) -Do not attempt Resuscitation.

A review of the hospice visit note addendum on 8/28/2019 showed II and Staff A discussed that the resident was a full code and that Staff A was working on getting a DNR. Staff A was also working on the funeral arrangements because the finances were tight.

A review of the file for Resident #10 showed diagnoses of dementia, hyperlipidemia, Parkinson's disease, and major depression.

A review of email sent from BB on 6/20/2021 at 7:46 a.m. showed that Resident #10 was lethargic, BB stated that Staff C was walking towards the room of Resident #10, 309B, with some papers in his/her hand. BB stated that he/she asked Staff C what she was doing, and Staff C stated that he/she was going to see if Resident #10 will give him/her and Staff A power of attorney (POA) since the resident did not one. Staff C also stated that Resident #10 needed to sign a DNR because his/her health was declining since returning from the hospital. BB stated to Staff C that Resident #10 was lethargic and was not even speaking, let alone, able enough to consent to anything. Approximately 30 minutes later, BB had seen Staff C come to the front of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PCH009912	A. BUILDING B. WING	08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNTIFUL HILLS	200 BOLTON DRIVE COMMERCE, GA 30529

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	building to the office of Staff A. BB heard Staff C tell Staff A that he/she got Resident to sign. BB stated that he/she went over to memory care unit to talk with two caregivers that were working memory care. BB stated that he/she started speak but KK immediately stated that he/she could not believe they actually did that to Resident #10. During an interview on 6/24/2021 at 10:10 a.m., KK stated that Resident #10 told him/her that he/she signed a document to allow Staff A to control his/her finances. During an interview on 8/27/2021 at 12:46 p.m., Staff A stated acknowledged the findings.

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{A 2510} SS= D	111-8-62-.25(1)(f) Supporting Residents' Rights. Each resident must be treated with dignity, kindness, consideration and respect and be given privacy in the provision of personal care. Each resident must be accorded privacy and freedom for the use of the bathroom at all hours. This REQUIREMENT is not met as evidenced by: >>>>Based on interview, the facility failed to treat each resident with dignity, kindness, consideration and respect. Findings include: During an interview on 6/11/2021, Resident # 03 stated that Staff F was ruff with him/her. During an interview on 6/17/2021 at 10:56 a.m., CC stated that he/she watched Staff F talked with Resident #11 in a very disrespectful tone. CC stated around March 2021, Resident #10 wanted to have some food that he/she was allergic to and Staff F told the resident that he/she cannot it. CC stated that as resident was asking for the food again, the resident started crying. CC stated that Staff F was getting agitated with the crying and started talking loud to the resident in an

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aggressive tone. CC stated that Staff F was talking in a loud and disrespectful manner to Resident #11. CC stated that a resident told him/her that Staff F threw a yoga ball and hit Resident # 11 in the head.

During an interview on 6/17/2021, EE stated that some residents were afraid of retaliation from staff if they talk about how staff have treated them. EE stated that Resident #01 did not want to talk about he/she was afraid of some staff. EE stated that he/she saw when the Staff F threw the ball and the hit Resident # 11 on the head. EE stated Resident # 01 told him/her that the resident was yelling. EE stated that Resident #01 told him/her that Staff F was not kind to the residents.

During an interview on 6/18/2021, Resident #01 acknowledged that he/she talked with EE and was afraid of staff and Staff F.

During an interview on 8/18/2021 at 4:15 p.m., Resident #01 stated that he/she was afraid to talk about what has been happening in the facility.

During an interview on 8/27/2021 at 12:46 p.m., Staff A stated he/she was not aware but staff must treat the residents in the memory care unit with respect.