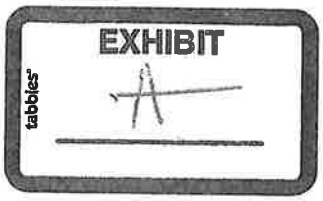
State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PCH009781	A. BUILDING: _____ B. WING _____	09/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNWOODY PLACE PERSONAL CARE HOME	1460 SOUTH JOHNSON FERRY ROAD ATLANTA, GA 30319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Opening Comments. >>>>The purpose of this visit was to investigate intake #GA00207176. The investigation started on 8/20/20 and was completed on 9/2/20.	A 000		
A 803 SS=K	111-8-62-.08(2)(a) Administration. The administrator or on-site manager of each personal care home must do the following: (a) Ensure that the policies and procedures are effective and enforced to support the health and safety of the residents. This RULE is not met as evidenced by: >>>>>Based on record review and staff interview and email, the administrator failed to ensure that the policies and procedures were enforced to support the health and safety of the residents for 1 of 4 sampled residents (Resident #1). Findings include: A review of the facility's incident report submitted to the Department on 8/4/20 showed an allegation of a financial theft from Resident #1. The report showed that FF notified the community that unauthorized charges appeared on the 8/4/20 bank statement of Resident #1. The report showed that FF placed a hold on the card and the community offered to place Resident #1 valuable items in a designated safe place for secure storage. The report showed that Resident #1 declined the offer and that the police was called. A review of an email received on 8/21/20 from Staff A showed two (2) fraudulent charges were posted on Resident #1's bank card. The email showed that $451.93 and $643.84 were charged	A 803	**1. Staff Education & Training** Executive Director and/or designee will ensure that staff will continue to receive education and training on the following upon hire date and quarterly thereafter: a. abuse, neglect, and exploitation, b. importance of listening carefully to residents' concerns c. their responsibility to promptly report to their supervisor all resident concerns and any co-worker who they may reason to believe is misappropriating residents' personal property and valuables d. Retaliation for good faith reporting is prohibited	11/13/2020

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A 803	Continued From page 1 and posted on Resident #1's bank card on 8/4/20, time unknown. The email further showed that the charges were made at two different stores at a local shopping mall in the vicinity of the facility. A review of the facility's policies and procedures for Resident Bill of Rights showed residents were to be free from mental, verbal, sexual and physical abuse, neglect and exploitation. The policy also showed that each resident had the right to use, keep and control his or her own personal property and possessions in the immediate living quarters. During an interview on 8/20/20 at 1:00 p.m., Staff A stated the facility was informed of financial theft that involved Resident #1's bank card. Staff A stated that the Power of Attorney (POA) of Resident #1 stated that between 7/2020 and 8/2020, there were two (2) unauthorized transactions in the amount of $643.84, and $451.93 charged to the card. Staff A stated that GG had video footage from the location of each time the card was used and the video footage was available for review. Staff A stated that the only policy and procedure that the facilty implemented was to continue to ask new residents if they wanted their valuable items to be secured in a locked safe by the facility. Staff A stated that on 8/10/2020, he/she was asked to review the video footage that was in GG custody and was unable to identifity the individual that charged the purchases to Resident #1's card. This violation was previously cited on 7/10/20.	A 803	**2. Resident Education & Reminders/ Security of Valuables** Executive Director will ensure that residents will receive education on the following via resident council meetings and in written memo from Executive Director: a. Importance of using locked drawers/safes to keep their valuables safe and to keep their locked drawers out of plain sight b. Assistance with purchasing safes and/or other appropriate security item to protect valuables c. Community provision of placing valuables in designated safe place until resident requests access to stored items d. Upon resident request lockboxes will installed in their unit **3. Monitoring of staff access to the community** Executive and/or designee will ensure that all employees will be issued key fobs for them gain access to the building. This will improve community's ability to track employees' entry into the building	12/16/2020 08/05/2020
A2512 SS=K	111-8-62-.25(1)(h) Supporting Residents' Rights. Each resident has the right to be free from	A2512		

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A2512	Continued From page 2 mental, verbal, sexual and physical abuse, neglect and exploitation. Each resident has the right to be free from actual or threatened physical or chemical restraints and the right to be free from isolation, corporal or unusual punishment and interference with the daily functions of living, such as eating or sleeping. This RULE is not met as evidenced by: ****>>>>Based on record review and interviews, the facility failed to ensure that each resident was free from mental, verbal, sexual and physical abuse, neglect and exploitation for 1 of 4 sampled residents (Resident #1). Finding include: A review of the Law Enforcement (LE) report dated 8/2/20, at 1:07 p.m., showed an officer responded to the facility for a fraud call. LE met with Staff E who stated that the POA of Resident #1 informed him/her of the unauthorized financial charges on the bank card of Resident #1. The report showed that Resident #1 bank statement was provided to the facility, and there were two (2) unauthorized transactions made for a total amount of $1095.77. The report showed that the officer attempted to interview Resident #1 about the incident and the resident appeared confused and could not provide any information about his/her fiances. The report showed that the officer suggested to Resident #1 to keep his/her purse closer to him/her or to secure it in an enclosed location. The report showed that contact was made with FF via phone who handled Resident #1 finances and all of Resident #1 account were closed. The report further showed that this was the second incident of finance theft in a month at this facility, the first being case 20-003432. The report showed that the card was charged at two different locations at two different shopping malls.	A2512		

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A2512	Continued From page 3 A review of an email received on 8/21/20 from Staff A showed that $451.93 and $643.84 were charged and posted on Resident #1 card on 8/4/20, time unknown. The email showed that the charges were made at two different stores at in a local shopping mall. A review of the 8/4/2020 bank transaction report for Resident #1 showed that the banks reversed the $1095.77 charge to a zero balance. A review of the file for Resident #1, admitted 2/4/17, showed diagnoses of depression, dementia, and an over active of bladder. During an interview on 8/20/20 at 1:00 p.m., Staff A stated the facility was informed of financial theft that involved Resident #1 bank card. Staff A stated that the Power of Attorney (POA) of Resident #1 stated that between 7/2020 and 8/2020, there were two (2) charges for $643.84 and $451.93. There were unauthorized transactions charged on card and there were no times given when the charges were made. Staff A stated that GG had video footage and the video footage was available for his/her review. Staff A stated that on 8/10/2020, he/she reviewed the video footage from both locations that the card was used and was unable to identify the individual that the made charges on Resident #1 card. During an interview on 9/1/20 at 9:15 a.m., Staff B stated that he/she worked the second shift as a med-tech. Staff B stated that his/her job duties were to pass medications to the resident, then exit the room if the resident did not need additional assistance. Staff B stated he/she was aware of the theft of Resident #1 card and had not heard who or how the card was stolen.	A2512		

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A2512	Continued From page 4 During an interview on 9/1/20 at 10:00 a.m., FF stated that he/she received Resident #1's August 2020 credit card statement and noticed two (2) unauthorized charges, one for $643.84 and the other charge was $451.93. FF stated that no staff or resident was authorized to use Resident #1's card and he/she informed the facility of card transactions. FF stated that he/she reported the fraudulent transactions to the bank and the bank reimbursed the charges on Resident #1's card. FF stated that this was the second time that Resident #1 had his/her card stolen at this facility and he/she closed out Resident #1 accounts. FF stated that Resident #1's card was used on 8/1/20 but the time of the transactions were not listed. During an interview on 9/1/20 at 11:47 a.m., Staff C stated that he/she worked the third shift at the facility. Staff C stated that he/she has never witnessed a resident valuable items or jewelry left out in plain sight. Staff C stated that he/she has never witnessed another staff search thru a resident personal items and if witnessed, it would be reported immediately to management. Staff C stated that the facility held a mandatory meeting and Resident's Rights were covered by management. During an interview on 9/1/20 at 1:35 p.m., GG stated that he/she was assigned to investigate the theft. GG stated that on 8/10/20 video footage was viewed from the locations of each purchase and the facility was unable to identity the individual that used Resident #1 card. GG stated that the facility was unable to identify the person and when and how Resident #1 card was stolen. GG stated that he/she had insufficient evidence to obtain an arrest warrant and the investigation	A2512		

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A2512	Continued From page 5 was ongoing. GG stated that he/she recently spoke with Resident #1 and the resident was unable to state when was the last time his/her card was seen. GG stated that this was the second theft of Resident #1 card and the prior incident was still pending. During an interview on 9/1/20 at 5:18 p.m., Staff D stated that he/she heard from other staff that theft occurred on the third shirt. Staff D stated that the staff name that was mentioned by other staff was terminated about two months ago. Staff D stated that he/she passed medication to Resident #1 and has never witnessed any of the resident valuable items left out in plain sight. During an interview on 9/2/20 at 3:16 p.m., Staff E stated that he/she filed a report with the local police. Staff E he/she spoke with Resident #1 about the incident and the resident appeared confused about the incident, showed no emotions or concerns, and asked "do I have to pay this back". Staff E stated that Resident #1 showed staff where his/her purse/wallet was kept and the purse was located on the back of the door that exited the bedroom. Staff E stated that GG advised Resident #1 to move the purse to a more secured location and Resident #1 refused. Staff E stated that Resident #1 was unable to state how many card were stored in his/her wallet and did not want staff to secure the card that were observed in the wallet. Staff E stated although Resident #1 had credit cards in his/her purse, FF had canceled those card. Staff E stated that plans of how Resident #1 credits were going to be secured were pending between FF and the facility. Staff E stated that investigation was ongoing at the facility. This violation was previously cited on 7/10/20.	A2512		

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A 000	Opening Comments. >>>> The purpose of this inspection was to investigate intake # GA00205999. The investigation was started on 6/29/20 and was completed on 7/9/20.	A 000		
A 803 SS=J	111-8-62-.08(2)(a) Administration. The administrator or on-site manager of each personal care home must do the following: (a) Ensure that the policies and procedures are effective and enforced to support the health and safety of the residents. This RULE is not met as evidenced by: >>>>Based on record review and staff interview and email, the administrator failed to ensure that the policies and procedures were enforced to support the health and safety of the residents for 1 of 5 sampled residents (Resident #1). Findings include: A review of the facility's incident report submitted to the Department on 6/16/20 showed an allegation of financial theft from Resident #1. The report showed a bank statement with three (3) $500.00 cash advances, two (2) on 6/6/20 and one (1) on 6/7/20 from an automated teller machine (ATM) . The report showed that the total amount charged on the bank card was $1,500.00. The report further showed that the police was called and an investigation was pending. A review of the facility's policies and procedures for Resident Bill of Rights showed that residents should be free from from mental, verbal, sexual and physical abuse, neglect and exploitation. The policy also showed that each resident has the right to use, keep and control of his or her own	A 803	**1. Staff Education & Training** Executive Director and/or designee will ensure that staff will continue to receive education and training on the following upon hire date and quarterly thereafter: a. abuse, neglect, and exploitation b. importance of listening carefully to residents' concerns c. their responsibility to promptly report to their supervisor all resident concerns and any co-worker who they may reason to believe is misappropriating residents' personal property and valuables d. Retaliation for good faith reporting is prohibited	11/13/2020

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A 803	Continued From page 1 personal property and possessions in the immediate living quarters. During an interview on 6/29/20 at 8:30 a.m., Staff A stated the facility was informed of financial theft that involved Resident #1's bank card. Staff A stated that the Power of Attorney (POA) of Resident #1 told him/her that between 6/6/2020 and 6/7/2020, there were five (5) $500.00 ATM withdrawals from a local bank and there were no times given when the withdrawals from the ATM were made. Staff A stated that the bank informed the facilty that a video footage from the ATM was available for review. Staff A stated that on 6/18/2020, he/she reviewed the video footage and identified the individual that made the cash withdrawals from the ATM as Staff D. Staff A stated that Staff D was terminated on 6/23/20 at 6:30 a.m. Cross reference to 2512	A 803	**2. Resident Education & Reminders/ Security of Valuables** Executive Director will ensure that residents will receive education on the following via resident council meetings and in written memo from Executive Director: a. Importance of using locked drawers/safes to keep their valuables safe and to keep their locked drawers out of plain sight b. Assistance with purchasing safes and/or other appropriate security item to protect valuables c. Community provision of placing valuables in designated safe place until resident requests access to stored items d. Upon resident request lockboxes will installed in their unit	12/16/2020
A2512 SS=J	111-8-62-.25(1)(h) Supporting Residents' Rights. Each resident has the right to be free from mental, verbal, sexual and physical abuse, neglect and exploitation. Each resident has the right to be free from actual or threatened physical or chemical restraints and the right to be free from isolation, corporal or unusual punishment and interference with the daily functions of living, such as eating or sleeping. This RULE is not met as evidenced by: ****>>>>Based on record review and interviews, the facility failed to ensure that each resident was free from mental, verbal, sexual and physical abuse, neglect and exploitation for 1 of 5 sampled residents (Resident #1). Finding include:	A2512	**3. Monitoring of staff access to the community** Executive and/or designee will ensure that all employees will be issued key fobs for them gain access to the building. This will improve community's ability to track employees' entry into the building	08/05/2020

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A2512	Continued From page 2 A review of the facility incident report submitted to the Department on 6/16/20 showed an allegation of financial exploitation of Resident #1. The report showed that there were five (5) cash advances made against the funds of Resident #1. The amount of withdrawals via the ATM were increments of $500.00 and three transactions were on 6/6/20 for (cash withdrawals) $1500.00 and two (2) on 6/7/20 for a total amount of $2518.15. The report showed that law enforcement (LE) was notified of the incident pending investigation. A review of the LE report dated 6/16/20, showed that at 3:16 p.m., an officer responded to the facility for a fraud call. LE met with Staff A who stated that the POA of Resident #1 informed him/her of the unauthorized financial charges on the bank card of Resident #1. The LE report showed that the bank statement for Resident #1 was provided to the facility, and there were five (5) unauthorized cash advance transactions made for a total amount of $2518.15. The report stated that three (3) $500.00 cash advances were made on 6/6/20 and two (2) $500.00 cash advance were made on 6/7/20 from a local ATM. The report showed that GG contacted the bank, canceled the card, and reported the cash advances were fraudulent The report also showed Resident #1 kept his bank card and pin number in his/her dresser next to the bed. The report further showed that Resident #1 was the victim, however, he/she was unable to provide any additional information. A review of the June 2020 bank statement for Resident #1 showed five, $500.00 cash advances. Three (3) cash advances were made on 6/6/2020 and two (2) were made on 6/7/2020.	A2512		

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A2512	Continued From page 3 The bank statement showed that the total amount charged on the bank card was $2,518.15 and the bank statement did not list the exact times of each cash advance. A review of the 7/1/2020 bank transaction report for Resident #1 showed that the bank reimbursed the $2,518.15 to the resident. During an interview on 6/29/20 at 8:30 a.m., Staff A stated the facility was informed of financial theft that involved the bank card of Resident #1. Staff A stated that the POA of Resident #1 told him/her that between 6/6/2020 and 6/7/2020, there were five (5) $500.00 ATM withdrawals from a local bank and there were no times given for the ATM withdrawals. Staff A stated that Resident #1 had never asked the facility to store his/her personal belongings and that the facility had a safe for residents' personal belonging, used only upon request. Staff A stated that the bank informed the facilty that a video footage was available for review, but would only release the video to the police. Staff A stated that on 6/18/2020, he/she reviewed the video footage from the ATM, and identified the individual that made the withdrawals as Staff D. Staff A stated that on 6/23/20 at 6:30 a.m., Staff D was terminated for violating the facility policies and procedures. Staff A stated that he/she was unable to determine when, where, or how Staff D received the bank card, but confirmed that Staff D worked at the facility from 6/5/20 to 6/9/20. Staff A stated that the police and the Department were notified of the incident and an internal investigation was initiated. During an interview on 6/29/20 at 12:31 p.m., GG stated that he/she received the June 2020 bank statement of Resident #1, and noticed there were three (3) $500.00 transactions at first, then	A2512		

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A2512	Continued From page 4	A2512		

realized there were five (5) $500.00 transactions. GG stated that the charges were made between 6/6/2020 and 6/7/2020 and before the charges Resident #1 had a zero balance. GG stated that the total amount charged on the card was $2518.15.00. GG stated that the bank charged $18.15 for the five (5) withdrawal fees and that he/she notified Staff A of the ATM cash advances. GG stated that he/she reported the fraudulent transactions to the bank and Resident #1 was reimbursed for the charges. GG stated that the police were notified and that he/she kept the bank card for Resident #1.

During an interview on 6/30/20 at 3:15 p.m., Staff B stated that he/she worked the second shift as a caregiver. Staff B stated that he/she had seen resident's personal belonging left out while at work at the facility, and that he/she never touched the resident's belonging. Staff B stated that he/she never heard about a theft of a resident's personal belonging and that the residents were checked on every two hours.

During an interview on 6/30/20 at 4:20 p.m., Staff D stated that he/she began employment at the facility on 1/14/2020. Staff D stated that he/she was terminated on 6/23/2020, reason unknown. Staff D stated that Staff A accused him/her of using Resident #1 bank card for cash withdrawals and the transactions were caught on video. Staff D stated that he/she never made cash advance withdrawals with Resident #1's bank card. Staff D stated that no officer or detective had contacted him/her about the incident, and that he/she had not been arrested. Staff D stated that he/she frequently provided care to Resident #1.

During an interview on 7/7/20 at 10:23 a.m., Resident #1 stated that he/she kept the bank

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PCH009781	A. BUILDING: _____ B. WING _____	07/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNWOODY PLACE PERSONAL CARE HOME	1460 SOUTH JOHNSON FERRY ROAD ATLANTA, GA 30319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A2512	Continued From page 5 card and pin number in the top dresser drawer next to his/her bed. Resident #1 was unable to state the last time he/she saw the bank card and did not know who use the card, or how the card was used. Resident #1 stated that no staff or resident was authorized to use his/her bank card, and the POA kept the bank card now for safekeeping. During two separate interviews on 7/7/20 between 11:00 a.m. and 12:00 p.m., Resident # 3 and Resident #5 stated that the facility had kept their valuable items in a safe at the facility. Resident #3 and Resident #5 stated that they had never witnessed or heard of a theft at the facility. A review of the file for Resident #1, admitted 8/15/15, showed diagnoses of hyperlipidemia, hypertension, and neoplasm of bladder. A review of the file for Staff D, hired 1/14/20, showed a satisfactory background check. The file also showed that Staff D completed abuse, neglect, and exploitation training on 1/20/19. The file further showed that Staff D was terminated on 6/23/20 at 6:30 a.m. A review of a maps website showed that the location of the ATM where cash advances were made was four miles from the facility.	A2512		