STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{L 000}	Initial Comments. The purpose of this visit was to conduct a compliance inspection and investigate GA00215776, GA00216359, and GA00216986. The investigation started on 8/4/2021 and was completed on 8/23/2021.
{L 0706} SS= D	111-8-63-.07(2)(e) Owner Governance. At a minimum, the policies and procedures that are developed must provide direction for the staff and residents on the following: ... (e) training and ongoing evaluation of staff, including specialized training if designated proxy caregivers are provided or memory care is offered; ... This REQUIREMENT is not met as evidenced by: <<<<Based on record review and interview, the facility failed to implement policies, procedures, and practices in the community that must provide direction for the staff and residents on the following: (e) training, including specialized training if memory care is offered for 4 of 14 sampled staff (Staff B, Staff D, Staff F, and Staff I). Findings include: A review of the files for Staff B, hired 2/15/2021, Staff F, hired 11/11/2020, and Staff G, hired 2/10/2021, showed no training in positive therapeutic interventions and activities such as exercise, sensory stimulation, role of the family, environment modifications, recognize cognitive and physical changes, and safety maintenance of residents. During an interview on 8/17/2021 at 12:20 p.m., Staff I stated that he/she had no training on positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills, environment modifications, role of family, ISP development. During an interview on 8/20/2021., Staff G stated that he/she did not receive training on positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills, environment modifications, role of family, and ISP development.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	During an interview on 8/20/2021., Staff F stated that he/she was not trained on positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills, environment modifications, role of family, and ISP development. During an interview on 8/20/2021, Staff A acknowledged the findings. Cross reference 1931, 1932, 1933, 1934,1935, 1936, 1937
{L 0709} SS= D	111-8-63-.07(2)(h) Owner Governance. At a minimum, the policies and procedures that are developed must provide direction for the staff and residents on the following: ... (h) medication management, procurement, the use of certified medication aides and professional oversight provided for such services; ... This REQUIREMENT is not met as evidenced by: <<<<Based on record review and interview, the facility failed to ensure that the policies and procedures were enforced to provide direction for the staff and residents on the following: medication management. Findings include: A review of the controlled drug record (CDR) on 7/17/2021 showed that the medication was given to Resident #7 five times. On 7/17/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D two times, and Staff J twice. On 7/18/2021 showed that the medication was given to Resident #7 five times. On 7/18/2021, the CDR showed the medication

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	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	was given to the resident by Staff K once, Staff D twice, and Staff J twice. On 7/19/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The CDR showed the medication was given to the resident by Staff K once, Staff C twice, and Staff J twice. On 7/20/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The CDR showed the medication was given to the resident by Staff K once, Staff D twice, Staff I once, and Staff L once. On 7/21/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The CDR showed the medication was given to the resident by Staff K once, Staff D twice, Staff B once, and Staff H once. On 7/23/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. On 7/23/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D twice, and Staff H twice. A review of the August 2021 MAR for Resident #7 showed how often staff gave Oxycodone HCL 10 mg tabs, prescribed to take one tablet every six hours as needed for pain, to the resident. During an interview on 8/17/2021 at 11:20 a.m., Resident #7 stated after a few days of his/her admission, he/she was given Oxycodone more than four times a day because he/she was in a lot of pain During an interview on 8/20/2021, Staff A acknoweledged the findings.
{L 0905} SS= D	111-8-63-.09(3)(a) Training. Initial Training for Staff Providing Hands-On Personal Services. In addition to the initial training required of all staff in paragraph (2) above, the administrator must ensure that staff hired to provide hands-on personal services to residents receive training within the first 60 days of employment which includes the following: (a) current certification in emergency first aid except where the staff person is a currently licensed health care professional; ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview the facility failed to ensure staff had a current certification in emergency first aid except where the staff person is a currently licensed health care professional for 2 of 14 sampled staff (Staff B and Staff D). Findings included: A review of the file for Staff B, hired 2/15/2021 and Staff C, hired 6/1/2021, showed no current certification in emergency first aid. During an interview on 8/20/2021, Staff A acknowledged the findings. During an interview on 8/23/2021, Staff B stated that the first aid training was expired, and he/she has paid for a new first aid class.
{L 0906} SS= D	111-8-63-.09(3)(b) Training. [The] administrator must ensure that staff hired to provide hands-on personal services to residents receive training within the first 60 days of employment which includes the following: ... (b) current certification in cardiopulmonary resuscitation where the training course required return demonstration of competency; ... This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure that staff hired to provide hands-on personal services to residents receive training within the first 60 days of employment which includes current certification in cardiopulmonary resuscitation (CPR) where the training course required return demonstration of competency for 2 of 7 sampled staff (Staff B and Staff G).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	Findings include: A review of the files for Staff B, hired 2/15/2021 and Staff G, hired 2/10/2021, showed no training in CPR. During an interview on 8/20/2021, Staff A acknowledged the findings. During an interview on 8/23/2021, Staff B stated that the CPR training certificate was expired, and he/she has paid for a class.
{L 0940} SS= D	111-8-63-.09(18)(c) Staffing. Residents must be supervised consistent with their needs. This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interviews, the facility failed to supervised residents consistent with their needs for 1 of 11 sampled residents (Resident 12). Findings include: During a tour of the facility on 8/6/2021 at 10:45 a.m., Resident #12 was observed asking for help for over seven minutes and no staff provided assistance until a request was made by DR. A review of the facility July 2021 Pendent report showed the following: July 01, 2021 1. Staff responded to one resident call alert after 15 minutes. July 02, 2021 1. Staff responded to three residents call alert after 15 minutes. 2. Staff responded to one resident call alerts after 20 minutes. 3. Staff responded to one resident call alert after 99 minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	July 03, 2021 1. Staff responded to two residents call alerts after 15 minutes. 2. Staff responded to one resident call alert after 20 minutes. 3. Staff responded to one resident call alert after 30 minutes. 4. Staff responded to one resident call alert after 99 minutes. July 04, 2021 1. Staff responded to two residents call alerts after 15 minutes. 2. Staff responded to one resident call alert after 20 minutes. 3. Staff responded to one resident call alert after 30 minutes. July 05, 2021 1. Staff responded to one resident call alert after 99 minutes July 06, 2021 1. Staff responded to one resident call alert after 20 minutes. 3. Staff responded to one resident call alert after 30 minutes. July 07, 2021 1. Staff responded to one resident call alerts after 70 minutes 2. Staff responded to two resident call alerts after 99 minutes July 08, 2021 1. Staff responded to one resident call alerts after 15 minutes 2. Staff responded to one resident call alert after 70 minutes July 09, 2021 1. Staff responded to five residents call alerts after 15 minutes. 2. Staff responded to two residents call alerts after 20 minutes. 3. Staff responded to one resident call alert after 25 minutes. 4. Staff responded to one resident call alert after 70 minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	5.Staff responded to two residents call alerts after 99 minutes. July 10, 2021 1. Staff responded to one resident call alert after 15 minutes. 2.Staff responded to two residents call alerts after 99 minutes. July 11, 2021 1. Staff responded to one resident call alert after 20 minutes. 2. Staff responded to two residents call alerts after 25 minutes. July 12, 2021 1. Staff responded to one resident call alert after 15 minutes. 2. Staff responded to two residents call alerts after 20 minutes. 3. Staff responded to one resident call alert after 25 minutes. 4. Staff responded to one resident call alert after 99 minutes. July 13, 2021 1. Staff responded to one resident call alert after 25 minutes. July 14, 2021 1. Staff responded to one resident call alert after 30 minutes. 2. Staff responded to five residents call alerts after 99 minutes. July 15, 2021 1. Staff responded to one resident call alert after 20 minutes. 2. Staff responded to one resident call alert after 30 minutes. 3. Staff responded to two residents call alerts after 70 minutes. 4. Staff responded to one resident call alert after 99 minutes July 16, 2021 1. Staff responded to one resident call alert after 15 minutes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

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	2.1. Staff responded to one resident call alert after 20 minutes 3. Staff responded to six residents call alerts after 30 minutes. 4. Staff responded to one resident call alert after 95 minutes. 5. Staff responded to three residents call alerts after 99 minutes July 17, 2021 1.Staff responded to two residents call alerts after 20 minutes 3. Staff responded to two residents call alerts after 30 minutes. July 18, 2021 1. Staff responded to one resident call alert after 25 minutes July 19, 2021 1. Staff responded to one resident call alert after 15 minutes. 2. Staff responded to one resident call alert after 20 minutes 3. Staff responded to one resident call alert after 30 minutes. 4. Staff responded to two residents call alert after 99 minutes. July 20, 2021 1. Staff responded to three residents call alert after 99 minutes. July 21, 2021 1. Staff responded to three residents call alerts after 20 minutes 2. Staff responded to three residents call alerts after 30 minutes. 3. Staff responded to four residents call alert after 99 minutes. During an interview on 8/20/2021, Resident # 9 stated the facility needs more staff. Resident #9 stated that one would be in the memory care unit and one staff would be in other section with one med-tech on the weekends. During an interview on 8/20/2021, Staff A acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

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{L 0947} SS= D	111-8-63-.09(19)(g) Staffing. Sufficient staff time must be provided by the assisted living community such that each resident: ... (g) is given assistance, if needed, with daily hygiene, including baths and oral care; ... This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to provide sufficient staff time must to each resident is given assistance, if needed, with daily hygiene, including baths and oral care for 1 of 11 residents sampled (Resident #5). Findings include: A review of the file for Resident # 5, admitted 6/28/2021, showed diagnoses of dementia, stroke (2020), hypertension, hyperlipemia, and GERD. A review of the facility notes showed on 7/23/2021, the hospice skilled was talking to his/her coworkers and Resident #5 came up to him/her and began talking. The resident tried to touch the face of the skilled nurse. The resident's hands smelled of bowel movement. The resident had stool on his fingers. The hopice nurse told Staff C and Staff N about the resident's fingers. During an interview on 8/6/2021 at 1:22 p.m., Staff N stated on 7/26/2021 around 9:00 a.m., the hospice nurse was visiting with Resident #5 and noticed that the fingers of the resident were dirty and asked could staff clean the resident's fingers. During an interview on 8/6/2021, Staff C stated that around 9:20 a.m. on 7/26/2021, the fingers of Resident #5 were dirty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	During an interview on 8/23/2021 at 8:35 a.m., FF stated that EE told him/her around 7/13/2021, he/she visited Resident #5 came to the door with blood on his/her robe and he/she thought that was unusual.
{L 1700} SS= D	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 record review and staff interview, the facility failed to provide protective and watchful oversight to meet the needs of the residents for 1 of 10 sampled residents (Resident #10). Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

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	A review of the facility incident reports showed on 7/26/2021 at 8:30 p.m.to Resident #10 was calling and stated that he/she drunk some perfume. Staff gave him/her some water and 30 ml of milk of magnesium. The family was notified. The physician was no notified on 7/26/2021. During an interview on 8/5/2021, Staff A stated that Resident #10 was seen by the physician on 7/27/2021. During an interview on 8/6/2021, Staff G stated on 7/26/2021 at 8:30 p.m., Resident #10 was sitting in the living room and was seated next to his/her friend. Staff G stated the resident told him/her that he/she had drunk perfume and his/her mouth was burning. Staff G stated that he/she monitoring the resident and took the bottle of perfume. Staff G stated the resident told him/her that his/her mouth was burning. Staff G stated that he/she gave the resident some water and called his/her supervisor and a family member. During an interview on 8/20/2021, Staff A acknowledged the findings.
{L 1931} SS= D	111-8-63-.19(1)(d)4. Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics: ... 4. positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills; ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to assigned staff in the unit with training with in the six months of training in positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills for 3 of 7 sampled (Staff D, Staff F, and Staff G). Findings include: A review of the files for Staff B, hired 2/15/2021, Staff F, hired 11/11/2020, and Staff G, hired 2/10/2021, showed no training in positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills. During an interview on 8/17/2021 at 11:45 a.m., Staff D stated that he/she was not trained on positive therapeutic interventions and activities such as exercise, sensory stimulation, activities of daily living skills, environment modifications, role of family, ISP development. During an interview on 8/20/2021, Staff A acknowledged the findings.
{L 1932} SS= D	111-8-63-.19(1)(d)5. Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics: ... 5. the role of the family in caring for residents with dementia, as well as the support needed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	the family of these residents; ... This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assigned staff in the unit with training with in the six months of training in the role of the family in caring for residents with dementia, as well as the support needed by the family of these residents for 3 of 7 sampled (Staff B, Staff F, and Staff G). Findings include A review of the files for Staff B, hired 2/15/2021, Staff F, hired 11/11/2020, and Staff G, hired 2/10/2021, showed no training in the role of the family in caring for residents with dementia, as well as the support needed by the family of these residents. During an interview on 8/20/2021, Staff A acknowledged the findings.
{L 1933} SS= D	111-8-63-.19(1)(d)6. Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics: ... 6. environmental modifications that can avoid problematic behavior and create a more therapeutic environment. ... This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assigned staff in the unit with training with in the six months of training in environmental modifications that can avoid problematic behavior and create a more therapeutic environment for 3 of 7 sampled staff (Staff D , Staff F, and Staff I). Findings include A review of the files for Staff B, hired 2/15/2021, Staff F, hired 11/11/2020, and Staff G, hired 2/10/2021, showed no training in environmental modifications that can avoid problematic behavior and create a more therapeutic environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	During an interview on 8/17/2021 at 11:45 a.m., Staff D stated that he/she was not on environmental modifications that can avoid problematic behavior and create a more therapeutic environment. During an interview on 8/17/2021 at 12:20 p.m., Staff I stated that he/she did not receive on environmental modifications that can avoid problematic behavior and create a more therapeutic environment. During an interview on 8/20/2021, Staff A acknowledged the findings.
{L 1934} SS= D	111-8-63-.19(1)(d)7. Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics: ... 7. 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 baseline care needs; ... This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assigned staff in the unit with training with in the six months of training in 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 baseline care needs for 3 of 7 sampled staff (Staff B, Staff F, Staff G). Findings include: A review of the files for Staff B, hired 2/15/2021, Staff F, hired 11/11/2020, and Staff G, hired 2/10/2021, showed no training in 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 baseline care needs. .During an interview on 8/20/2021, Staff A acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{L 1935} SS= D	111-8-63-.19(1)(d)8. Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics: ... 8. new developments in dementia care that impact the approach to caring for the residents in the special unit; ... This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assigned staff in the unit with training with in the six months of training in new developments in dementia care that impact the approach to caring for the residents in the special unit for 3 of 7 sampled staff (Staff B, Staff F, and Staff G). Findings include: A review of the files for Staff B, hired 2/15/2021, Staff F, hired 11/11/2020, and Staff G, hired 2/10/2021, showed no training in new developments in dementia care that impact the approach to caring for the residents in the special unit. During an interview on 8/20/2021, Staff A acknowledged the findings.
{L 1936} SS= D	111-8-63-.19(1)(d)9. Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics: ... 9. skills for recognizing physical or cognitive changes in the resident that warrant seeking medical attention; ... This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assigned staff in the unit with training with in the six months of training in skills for recognizing physical or cognitive changes in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	resident that warrant seeking medical attention for 3 of 7 sampled staff (Staff B, Staff F, and Staff G). Findings include: A review of the files for Staff B, hired 2/15/2021, Staff F, hired 11/11/2020, and Staff G, hired 2/10/2021, showed no training in skills for recognizing physical or cognitive changes in the resident that warrant seeking medical attention. During an interview on 8/20/2021, Staff A acknowledged the findings.
{L 1937} SS= D	111-8-63-.19(1)(d)10. Initial Staff Training. Within the first six months of employment, staff assigned to the unit shall receive training in the following topics: ... 10. skills for maintaining the safety of residents with dementia. This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to assigned staff in the unit with training with in the six months of training in skills for maintaining the safety of residents with dementia for 3 of 7 sampled (Staff B, Staff F, and Staff G). Findings include: A review of the files for Staff B, hired 2/15/2021, Staff F 11/11/20 and Staff G, hired 2/10/2021, showed no training in skills for maintaining the safety of residents with dementia. During an interview on 8/20/2021, Staff A acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

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{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 review and interview, the facility failed to provide medication administration services to the residents in accordance with physicians' orders, the needs of the residents and these rules for 1 of 10 sampled resident (Resident # 7). Findings include: A review of the controlled drug record (CDR) on 7/17/2021 showed that the medication was given to Resident #7 five times. On 7/18/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D two times, and Staff J twice. On 7/18/2021 showed that the medication was given to Resident #7 five times. On 7/18/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D twice, and Staff J twice. On 7/19/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The CDR showed the medication was given to the resident by Staff K once, Staff C twice, and Staff J twice. On 7/20/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The CDR showed the medication was given to the resident by Staff K once, Staff D twice, Staff I once, and Staff L once. On 7/21/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The CDR showed the medication was given to the resident by Staff K once, Staff D twice, Staff B once, and Staff H once. On 7/23/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. On 7/23/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D twice, and Staff H twice. A review of the August 2021 MAR for Resident #7 showed the how often that staff gave Oxycodone HCL 10mg tabs, prescribed to take one tablet every six hours as needed for pain, to the resident. During an interview on 8/17/2021 at 11:20 a.m., Resident #7 stated after a few days of his/her admission, he/she was given more Oxycodone than four times a day because he/she was in a lot of pain. During an interview on 8/20/2021, Staff A acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

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{L 2049}	111-8-63-.20(9) Maintaining Records on Medication Assistance. Maintaining Records on Medication Assistance and Administration. Where the assisted living community either provides assistance with, or supervision of self-administered medications or administers medications to residents, the community must maintain a daily Medication Assistance Record (MAR) for each resident who receives assistance or administration. The MAR must include the name of the specific resident, any known allergies, the name and telephone number of the resident's health care provider, the name, strength and specific directions including key side effects and adverse reactions for use of each medication and a chart for staff who provide assistance or administration to record initials, time and date when medications are taken, refused or a medication error is identified (e.g. missed dosage). The staff providing the assistance or administration of medications must update the MAR each time the medication is offered or taken. This REQUIREMENT is not met as evidenced by: >>>>Based on record review and interview, the facility failed to update the Medication Administration Record (MAR) each time the medication was offered or taken for 1 of 10 sampled residents (Resident #7). Findings include: A review of the August 2021 MAR for Resident #7 showed the how often that staff gave Oxycodone HCL 10mg tabs, prescribed to take one tablet every six hours as needed for pain, to the resident. On 7/17/2021, the MAR showed the medication was administered four times to the resident. However, on 7/17/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. On 7/17/2021, the CDR showed the medication was administered to the resident by Staff K once, Staff D twice, and Staff J twice. The MAR showed that the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

was given to the resident by Staff K once, Staff D twice, and Staff J once. The MAR and CDR did not match up, as the CDR showed that five medications were administered to the resident while the MAR showed four medications were given.

On 7/18/2021, the MAR showed the medication was given four times to the resident. However, on 7/18/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. On 7/18/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D twice, and Staff J twice. The MAR showed that the medication was given to the resident by Staff K once, Staff D twice, and Staff J once.

On 7/19/2021, the MAR showed the medication was given two times to the resident. However, on 7/19/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The MAR showed that the medication was given to the resident by Staff C once and Staff I once. On 7/19/2021, the CDR showed the medication was given to the resident by Staff K once, Staff C twice, and Staff J twice. The MAR and CDR did not match up, as the CDR showed that five medications were administered to the resident while the MAR showed that two medications were given. On 7/19/2021, no medication was given by Staff J on the CDR.

On 7/20/2021, the MAR showed the medication was given four times to the resident. However, on 7/20/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The MAR showed that the medication was given to the resident by Staff J once, Staff D twice, and Staff I once. On 7/20/2021, the CDR showed the medication was given to the resident by Staff J once, Staff D twice, Staff I once, and Staff H once. The MAR and CDR did not match up, as the CDR showed that five medications were administered to the resident while the MAR showed that four medications were given. On 7/20/2021, Staff H was not listed on the MAR as to have administered medication.

On 7/23/2021, the MAR showed the medication was given two times to the resident. However, on 7/23/2021, the controlled drug record (CDR) showed that the medication was given five times to the resident. The MAR showed that the medication was given to the resident by Staff D two times. On 7/23/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D twice, and Staff H twice. The MAR and CDR did not match up, as the CDR showed that five medications were administered to the resident while the MAR showed that two medications were given. On 7/23/2021, Staff K and Staff H were not listed on the MAR as to have administered the medication.

On 7/24/2021, the MAR showed the medication was given two times to the resident. However, on 7/24/2021, the controlled drug record (CDR) showed that the medication was given three times to the resident. The MAR showed that the medication was given to the resident by Staff K once and Staff H once. On 7/24/2021, the CDR showed the medication was given to the resident by Staff K once, Staff H once, and Staff I once. The MAR and CDR did not match up, as the CDR showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	that three medications were administered to the resident while the MAR showed that two medications were given. On 7/25/2021, the MAR showed the medication was given three times to the resident. However, on 7/25/2021, the controlled drug record (CDR) showed that the medication was given four times to the resident. The MAR showed that the medication was given to the resident by Staff K once, Staff I once, and Staff H once. On 7/25/2021, the CDR showed the medication was given to the resident by Staff K once, Staff I twice, and Staff H once. The MAR and CDR did not match up, as the MAR showed that three medications were given while the CDR showed that four medications were administered to the resident. On 7/26/2021, the MAR showed the medication was given twice to the resident. However, on 7/26/2021, the controlled drug record (CDR) showed that the medication was given three times to the resident. The MAR showed that the medication was given to the resident by Staff K once and Staff J once. On 7/26/2021, the CDR showed the medication was given to the resident by Staff K once and Staff J twice. The MAR and CDR did not match up, as the MAR showed that two medications were given while the CDR showed that three medications were administered to the resident. On 7/29/2021, the MAR showed the medication was given three times to the resident. However, on 7/29/2021, the controlled drug record (CDR) showed that the medication was given four times to the resident. The MAR showed that the medication was given to the resident by Staff D once and Staff H twice. On 7/29/2021, the CDR showed the medication was given to the resident by Staff L once, Staff D once, and Staff H twice. The MAR and CDR did not match up, as the MAR showed that three medications were given while the CDR showed that four medications were administered to the resident. Staff L was not listed on the MAR as given the medication. On 7/30/2021, the MAR showed the medication was given three times to the resident. However, on 7/30/2021, the controlled drug record (CDR) showed that the medication was given four times to the resident. The MAR showed that the medication was given to the resident by Staff K twice and Staff D once. On 7/30/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D once, and Staff J twice. The MAR and CDR did not match up, as the MAR showed that three medications were given while the CDR showed that four medications were administered to the resident. Staff J was not listed on the MAR as given the medication. On 7/31/2021, the MAR showed the medication was given to the resident once. However, on 7/31/2021, the controlled drug record (CDR) showed that the medication was given four times to the resident. The MAR showed that the medication was given to the resident by Staff K once and Staff D once. On 7/31/2021, the CDR showed the medication was given to the resident by Staff K once, Staff D once, and Staff M twice. The MAR and CDR did not match up, as the MAR showed that one was given while the CDR showed that four medications were administered to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

resident.

On 8/2/2021, the MAR showed the medication was given to the resident three times. However, on 8/2/2021, the controlled drug record (CDR) showed that the medication was given to the resident four times. The MAR showed that the medication was given to the resident by Staff K once, Staff I once, and Staff B once. On 8/2/2021, the CDR showed the medication was given to the resident by Staff K once, Staff I twice, and Staff B once. The MAR and CDR did not match up, as the MAR showed that three medications were administered while the CDR showed that four medications were administered to the resident.

On 8/3/2021, the MAR showed the medication was given to the resident four times. On the controlled drug record (CDR) showed that the medication was given to the resident five times. The MAR showed that the medication was given to the resident by Staff K once, Staff I once, and Staff H twice. On 8/3/2021, the CDR showed the medication was given to the resident by Staff K once, Staff I twice, and Staff H twice. The MAR and CDR did not match up, as the MAR showed that four medications were administered while the CDR showed that five medications were administered to the resident.

On 8/4/2021, the MAR showed the medication was given to the resident two times. On the controlled drug record (CDR) showed that the medication was given to the resident four times. The MAR showed that the medication was given to the resident by Staff K once and Staff N once. On 8/4/2021, the CDR showed the medication was given to the resident by Staff K once, Staff I twice, and Staff B once. The MAR and CDR did not match up, as the MAR showed that two medications were administered while the CDR showed that four medications were administered to the resident. Staff I's initials were not listed on the MAR.

On 8/5/2021, the MAR showed the medication was given to the resident two times. On the controlled drug record (CDR) showed that the medication was given to the resident four times. The MAR showed that the medication was given to the resident by Staff K once and Staff H once. On 8/5/2021, the CDR showed the medication was given to the resident by Staff K once, Staff I twice, and Staff H once. The MAR and CDR did not match up, as the MAR showed that two medications were administered while the CDR showed that four medications were administered to the resident. Staff I's initials were not listed on the MAR.

During an interview on 8/17/2021, BB stated that staff have forgotten to update the MAR when giving medications. BB stated that staff have made some medication errors. BB stated that the computer will alert staff of the time to administer medication to the resident. BB stated that when the medication has taken out of the bubble pack, staff will administer the medication, and update the electronic MAR and CDL.

During an interview on 8/17/2021 at 11:45 a.m., Staff D stated that the computer will alert staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	when a resident needed medication. Staff D stated staff the medication protocol has been that staff sign the electronic MAR and update the CDL when administering the medications including narcotics that have been prescribed as needed to the residents. During an interview on 8/17/2021 at 12:20 p.m., Staff I stated the computer will send an alert for staff to administer the medication to a resident. Staff I stated that he/she will get the medication, go the resident, take the medication out of the package, administer the medication to a resident, and update the electronic MAR and CDL. Staff I stated that each time that he/she has administered medication to a resident, he/she has initialed the electronic MAR. Staff I stated that the med techs count the narcotics at the end of each work shift. Staff I stated that he/she has given oxycodone to Resident # 7 at 8:00 a.m. and not until 1:00 p.m., and around 2:00 p.m During an interview on 8/17/2021, Staff A stated that he/she was unaware that some staff were not intialing the MAR During an interview on 8/20/2021, Staff A acknowledged the findings.
{L 2057} SS= D	111-8-63-.20(10) Orders Required for All Medications. Orders Required for All Medications. An assisted living community must not allow its staff to assist with, provide supervision of self-administered medications or administer any medications, including over-the-counter medications, unless there is a physician's order specifying clear instructions for its use on file for the resident. This REQUIREMENT is not met as evidenced by: <<<<Based on interview and record review, the facility failed to not allow its staff to assist with, provide supervision of self-administered medications or administer any medications unless there is a physician's order specifying clear instructions for its use on file for the resident. for 1 of 10 sampled residents (Resident # 2). Findings include: A review of the file for Resident #2, admitted 9/20/20, showed diagnoses of atrial fibrillation, congestive heart failure, dementia, hypertension, and osteoporosis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	A review of the physician modified order for Resident #2 showed on 8/3/2021, showed that aspirin, Cyclobenzaprine and Levofloxacin were discontinued. A review of the August 2021 (MAR) medication administration record for Resident #2 showed medications were administered to the resident on the following: 1. Albuterol sulfate inhaler, prescribed to inhale two puffs three times a day, was given on 8/4/2021 at 8:00 a.m., 12:00 p.m., 5:00 p.m., and 8/5/2021 at 8:00 a.m. 2. Aspirin low tab 81 mg, prescribed to take one tablet by mouth every evening, was given on 8/4/2021 at 8:00 p.m. 3. Levofloxacin 250 mg tabs, prescribed to take one tablet by mouth one time daily, was given on 8/4/2021 and 8/5/2021 at 8:00 a.m. During an interview on 8/5/2021, Staff C stated the medications were discontinued on the physician order on 8/3/2021 but were given to the resident after that date. During an interview on 8/20/2021, Staff A acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
{L 2058} SS= D	111-8-63-.20(11) Timely Management of Medication Procurement. Timely Management of Medication Procurement. Where the assisted living community procures medications on behalf of the residents, the community must obtain new prescriptions within 48 hours of receipt of notice of the prescription or sooner if the prescribing physician indicates that a medication change must be made immediately. If the pharmacy does not have the medication needed for the immediate change, available and has not obtained further directions from the physician, the community must notify the physician of the unavailability of the prescription and request direction. Refills of prescribed medications must be obtained timely so that there is no interruption in the routine dosing. Where the assisted living community 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 indicates that the medication change must be made immediately. This REQUIREMENT is not met as evidenced by: <<<<Based on interview and record review, the facility failed to ensure refills of prescribed medications were obtained timely so that there was no interruption in the routine dosing for 3 of 11 sampled residents (Resident # 1, Resident #3, and Resident #7). Findings include: Resident #1 A review of the file for Resident #1, admitted 6/9/2021 showed diagnoses of major depressive disorder, memory deficit, diabetes, hypertension, and hyperlipemia. Resident #1 was on a low sodium and diabetic diet. A review of the physician order for Resident #1 showed that he/she needed to check blood sugar level twice a day at breakfast and at dinner. A review of the June 2021 MAR for Resident #1 showed on 6/4/2021 and 6/18/2021 no test strips in the facility. During an interview on 8/4/2021, AA stated that Resident #1 was diagnosed diabetics and the facility has been out of strips to check his/ her blood sugar level for 24 hours. AA stated that staff told him/her that the strips would not delivered until 3:00 p.m. During an interview on 8/18/2021 at 4:29 p.m., CC stated that Resident #1 did not have diabetic test strips and the strips were ordered for him/her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

Resident # 3

A review of the August 2021 (MAR) medication administration record for Resident #3 showed the medications were unavailable to administer to the resident on the following dates and times:

1. Amlodipine Besylate 5 mg tab, prescribed to take once daily.
1. 8/1/2021 at 8:00 a.m.
2.8/2/2021 at 8:00 a.m.

2. Docusate Sodium 100 mg capsule, prescribed to take 1 capsule by mouth twice a day.
1. 8/1/2021 at 8:00 a.m.
2.8/2/2021 at 8:00 a.m.

3. Duloxetine HCL dr 60 capsule, prescribed to take 1 capsule by mouth once daily.
1. 8/1/2021 at 8:00 a.m.
2.8/2/2021 at 8:00 a.m.

4. EQ Aspirin EC 81 mg tablet, prescribed to take one tablet by mouth once daily.
1.8/2/2021 at 8:00 a.m.

5. Famotidine 20 mg tablet, prescribed to take one tablet by mouth twice daily.
1. 8/2/2021 at 8:00 a.m.

6. Ferrous Sulfate 325 mg tablet, prescribed to take one tablet by mouth twice day with food.
1. 8/2/2021 at 8:00 a.m.

7. Hydrochlorothiazide 25 mg, prescribed to take one tablet by mouth once daily.
1. 8/2/2021 at 8:00 a.m.

Resident # 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
	A review of the July 2021 (MAR) medication administration record for Resident #7 showed the medications were unavailable to administer to the resident on the following dates and times: 1. Allopurinol 300 mg, prescribed to take one tablet by mouth once daily. 1. 7/8/2021 at 8:00 a.m. 2. Aspirin EC 81 mg tablet, prescribed to take one tablet by mouth once daily. 1.7/8/2021 at 8:00 a.m. 3. Cetirizine HCL 10 mg tablet, prescribed to take one tablet by mouth once daily. 1.7/8/2021 at 8:00 a.m. 4. Diltiazem 24 HR ER 360 MG CAP, prescribed to take one tablet by mouth once daily. 1.7/8/2021 at 8:00 a.m. 5. Eliquis 5 mg tablet, prescribed to take one tablet by mouth twice daily. 1.7/8/2021 at 8:00 a.m. During an interview on 8/20/2021 at 10:01 a.m., Resident #9 stated that he/she had not received his/her medication, Tylenol in June. Resident #9 stated the medication was held for weeks. During an interview on 8/20/2021, Staff A acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

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{L 2100} SS= D	111-8-63-.21(1) Nutrition and Food Preparation. Regularly Scheduled Meals. The assisted living community must provide a minimum of three regularly scheduled well-balanced meals per day seven days a week which meet the nutritional needs of residents, and must provide therapeutic diets as ordered by the residents' healthcare providers for residents that require special diets. There must be no more than fourteen hours elapsing between the scheduled evening and morning meals. This REQUIREMENT is not met as evidenced by: <<<<Based on observation and interview, the facility failed to provide therapeutic diets as ordered by the residents' healthcare providers for residents that require special diets for 1 of 10 sampled residents (Resident #3). Findings include: During a tour of the facility on 8/5/2021 at 12:29 p.m., the foods served for lunch were tacos with ground beef, cake, and lemonade, and at 5:19 p.m., the foods served for dinner were potato soup, potato chips, a sandwich on white bread, tea, and orange jello. A review of the file for Resident #3, admitted on 4/30/2021, showed diagnoses of osteoporosis, degenerative disc disease, and diabetes. During an interiew on 8/5/2021 at 12:09 p.m., Resident #3 stated he/she has not ate any fruits and vegetables in recently. Resident #3 stated that foods have not been served according to his/her diabetic dietary needs. During an interiew on 8/20/2021 at 10:01 a.m., Resident #9 stated served potatoes and white bread sandwich. Resident #9 stated the food consisted carbohydrates, sodium, and starches. Resident #9 stated the diet was not well- balanced. During an interview on 8/20/2021, Staff A acknowledged the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ALC000571	A. BUILDING B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY GARDENS ASSISTED LIVING AND MEMORY CARE	138 GATEWAY LANE BETHLEHEM, GA 30620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)