GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Caylee Noggle, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

December 2, 2021

Ken Williams, Administrator
Thrive On Skidaway
5 Lake St
Savannah, GA 31411

Dear Mr. Williams:

IMPORTANT NOTICE, PLEASE READ: Any new rule and/or rule changes are available on the Department of Community Health (DCH) website at www.dch.georgia.gov. Select Healthcare Facility Regulation, then Laws and Regulations, and then Assisted Living Communities (25 or more residents). Please check the DCH website periodically for updates, information, and training opportunities.

Report of Most Recent Survey

On November 18, 2021, staff from the Department of Community Health (DCH), Healthcare Facility Regulation Division (HFRD), Personal Care Home Program, conducted a survey of Thrive On Skidaway, located at 5 Lake St, Savannah, Georgia. Based on the survey findings, five violations of the Rules and Regulations for Assisted Living Communities, Chapter 111-8-63, were cited. Attached is a copy of the Survey Report. Please note that the survey findings are subject to supervisory review. Any violations cited may be deleted, corrected and/or additional violations cited based on that review. Any revisions of the survey report will be sent under separate cover.

Notice to Correct Violations / Enforcement Action

Pursuant to the Rules and Regulations for Assisted Living Communities, Chapter 111-8-63, and the Rules and Regulations for Enforcement of General Licensing and Enforcement Requirements, Chapter 111-8-25, the Department may impose a sanction for the violation of any rule. Notice to the governing body regarding the imposition of a sanction will be sent under separate cover. Failure to correct violations or failure to maintain compliance once corrections are made may result in further sanctions, including revocation of your permit.

Posting of the Inspection Report and Plan of Correction (POC)

A copy of this inspection report and plan of correction, if required, must be displayed in the assisted living community in a location that is routinely used by the community to communicate information to residents and visitors. The POC should not be sent to the Department.

To be acceptable, the POC must:

- Identify the methods and procedures to be used in the correction of the deficiencies;
- Identify the dates corrections have or will be completed; and
- Specify how the residence will monitor the corrections to achieve and maintain compliance.

The date by which corrections must be completed shall be no later than thirty (30) days from the date of the survey.

Statement of Disagreement

If the administrator/on-site manager disagrees with any of the deficiencies cited in this report, he/she may send a written statement of disagreement to the Regional Director to be reviewed. This must be submitted within ten (10) days of receipt of this letter and must include documentation, witness statements or other evidence showing the deficiency was cited in error. Failure to submit appropriate evidence will not alter the survey results.

If you have any questions or if we may be of assistance, please do not hesitate to call or write us.

Sincerely,

Irene Hubbard, RPN

Irene Hubbard, Regional Director
Personal Care Home Program
Healthcare Facility Regulation Division

Attachment

cc: Facility File

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
	ALC000656	A. BUILDING: _____ B. WING _____	C 11/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE ON SKIDAWAY	5 LAKE ST SAVANNAH, GA 31411

(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
L 000	Initial Comments. >>>>The purpose of this visit was to investigate intake GA00218939 and conduct the compliance inspection. An onsite visit was made to the facility on 11/17/21. The investigation was completed on 11/18/21.	L 000		
L 910 SS=D	111-8-63-.09(4) Trained Staff Present. Trained Staff Present. At least two staff who have completed the minimum training requirements of Rule 111-8-63-.09(2)(a) through (d) and (3)(a) through (e) above must be present in the assisted living community at all times any residents are present, with at least one staff person on each occupied floor, to provide necessary oversight and assistance to staff providing hands-on personal services who have not completed the training, to ensure that care and services are delivered safely and in accordance with these rules. This RULE is not met as evidenced by: >>>>Based on observation, record review and interview, the facility failed to ensure at least two staff who have completed the minimum training requirements of Rule 111-8-63-.09(2)(a) through (d) and (3)(a) through (e) must be present in the assisted living community at all times any residents are present, with at least one staff person on each occupied floor, to provide necessary oversight and assistance to staff providing hands-on personal services who have not completed the training, to ensure that care and services are delivered safely and in accordance with these rules. Findings include: Observation on 11/17/21 at 11:45 a.m. showed no caregiver on the second floor of the Assisted	L 910	Effective 12/17/21, the community is assigning breaks to include coverage to assure a trained staff is present on each floor The community continues to recruit to build the size of the overall trained team to provide additional options to assure compliance The Health & Wellness Director (HWD) will assure compliance with daily scheduling The Community President will monitor compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kenneth Willis TITLE President (X6) DATE 12/14/21

State of GA, Healthcare Facility Regulation Division

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L 910	Continued From page 1 Living Facility (ALF), which had two stories. One caregiver, Staff C, was on the first floor. A review of the work schedule, Staff C and Staff G were to work in ALF 7:00 a.m. to 3:00 p.m. The facility census sheet showed 6 residents on the first flor and 5 residents on the second floor of ALF. During an interview on 11/17/21 at that time, Staff C stated Staff D was assigned to the second floor of the ALF, but was on lunch break. This left only one person covering both floors. During an interview on 11/17/21 at 12:45 p.m., Staff A stated he/she did not know until alerted by the Department representative that an ALF caregiver had called out that morning. Staff A admitted there should be one caregiver on each floor but this had not happened when Staff D went to lunch.	L 910		
L1010 SS=D	111-8-63-.10(10) Community Accountability. No memory care center shall be operated and no residents admitted without a certificate which is current under these rules and regulations. Authority: O.C.G.A. §§ 31-2-7, 31-2-8 and 31-7-1 et seq. This RULE is not met as evidenced by: >>>>Based on observation and interview, the facility failed to obtain a memory care certificate. Findings include: Observation on 11/17/21 showed no memory care certificate displayed for the facility memory care unit. The current census in the memory care unit was 7 residents.	L1010	The Community submitted the Memory Care Certification and payment through the Portal on 12/14/21	

Kent M. Willis President 12/14/21

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L1010	Continued From page 2 An electronic message received from Staff A on 11/18/21 showed Staff A stated the facility had not yet applied for a memory care certificate.	L1010		
L1933 SS=D	111-8-63-.19(1)(e). Special Adm Req for Memory Ctr Placement. Special Admission Requirements for Memory Center Placement. Residents must have a physician's report of physical examination completed within 30 days prior to admission to the center on forms made available by Department. The physical examination must clearly reflect that the resident has a diagnosis of probable Alzheimer's Disease or other dementia and has symptoms which demonstrate a need for placement in the center. However, the center may also care for a resident who does not have a probable diagnosis of Alzheimer's Disease or other dementia, but desires to live in this center and waives his or her right to live in a less restrictive environment. In addition, the physical examination report must establish that the potential resident of the center does not require 24-hour skilled nursing care. This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to enusre residents have a physician's report of physical examination completed within 30 days prior to admission to the center on forms made available by Department. The physical examination must clearly reflect that the resident has a diagnosis of probable Alzheimer's Disease or other dementia and has symptoms which demonstrate a need for placement in the center for 1 of 2 sampled residents (Resident #2). Findings include:	L1933	Upon Inspection, resident #2 did not have a diagnosis of dementia on the Physician's Report Resident #2 has moved out of 12/1/21 on 12/12/21, the community completed an audit of all Physician's reports for all residents residing in memory care and found all to be in compliance. Effective 12/1/21, the Health & Wellness Director (HWD) or designee will review the Physician's Report Prior to move-in to memory care to assure required Diagnosis Effective 1/1/2022, the community President or designee will conduct a quarterly audit of all Physician reports for residents residing in memory care to assure on-going compliance	

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L1933	Continued From page 3 A review of the files for Resident #2 showed admitted 9/11/21, a physical examination report listing major depressive disorder without psychotic features as the diagnosis. There was no diagnosis of dementia. During an interview on 11/17/21 at 2:00 p.m., Staff A stated the physical examination report for Resident #2 did not list dementia as a diagnosis. Staff A stated Resident #2 did have short term memory loss but the phsyician form did not reflect this.	L1933		
L1935 SS=D	111-8-63-.19(1)(g). Individual Written Care Plan and Reviews. Individual Written Care Plan and Reviews. The resident's written care plan will be developed or updated by staff with at least one member of the specialized memory care staff providing direct care participating. Input from each shift of direct care staff that provides care to the resident will be requested. All team members participating shall sign the written care plan and the plan will be shared with the direct care staff providing care to the resident and serve as a guide for the delivery of care to the resident. The resident's family shall participate in the development of the plan, if possible, with incorporation of family and personal history to support a person-centered approach to care. The written care plan must be reviewed at least quarterly and modified as changes in the resident's needs occur. This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure the resident's family participated in the	L1935	on 12/1/21, the community completed an audit of Care Plans for residents residing in memory care, which concluded that 3 care plans did not include a review and signature or documentation of review by Phone As of 12/16/21, three care meetings will be completed. The third family is on vacation until 12/20/21 and will set appointment immediately upon return. The community President provided re-education with the HWD and Memory care Coordinator on 12/2/21 The HWD will assure family participation in the completion of Care Plans with proper documentation →	

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L1935	Continued From page 4 development of the resident's written care plan for 2 of 2 sampled residents (Resident #1, Resident #2). Findings include: A review of resident files showed Resident #1, admitted 9/10/21, had a care plan developed 9/10/21 and Resident #2, admitted 9/11/21 had care plans developed 9/11/21 and 10/11/21. None of these care plans had been signed by family or had documentation the care plans had been shared with family in any way. During an interview on 11/17/21, Staff A stated there was no documentation to show care plans had been shared with families of Resident #1 and Resident #2. Staff A stated he/she knew the care plans were to be shared with family.	L1935	The HWD or designee will conduct a quarterly audit of all care plans to assure proper review, signature or, if applicable, documentation of telephonic review	
L2015 SS=D	111-8-63-.20(5)(d) Certified Medication Aide Requirements. An assisted living community using certified medication aides to administer specific medications must do all of the following: ... (d) Quarterly Drug Regimen Reviews. Secure the services of a licensed pharmacist to perform all of the following duties: 1. Conduct quarterly reviews of the drug regimen for each resident of the assisted living community and report any irregularities to the assisted living community administration. 2. Remove for proper disposal any drugs that are expired, discontinued or in a deteriorated condition or where the resident for whom such drugs were ordered is no longer a resident. 3. Establish or review policies and procedures for safe and effective drug therapy, distribution, use and control. 4. Monitor compliance with established policies	L2015	on 12/2/21, the community arranged for quarterly med tech reviews by the Pharmacy Partner, Omnicare. on 12/9/21, the pharmacy Partner, Omnicare completed Medication Aid reviews The community will continue to utilize pharmacy to complete reviews each quarter. The community will maintain current and subsequent reviews in a medication Aide binder for tracking and future review	

Trent M. Williams President 12/14/21

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L2015	Continued From page 5 and procedures for medication handling and storage. This RULE is not met as evidenced by: >>>>Based on record review and interview, the facility failed to ensure an assisted living community using certified medication aides (CMA) to administer specific medications must secur the services of a licensed pharmacist to conduct quarterly reviews of the drug regimen for each resident of the assisted living community and report any irregularities to the assisted living community administration for 2 of 2 sampled staff (Staff C, Staff F). Findings include: A review of staff files showed Staff C, hired 3/11/21, CMA certified 3/12/21 and Staff F, hired and certified 4/21/21, had no documentation of a quarterly review by a licensed pharmacist. During an interview on 11/17/21, Staff A stated the facility CMAs had not had quarterly reviews.	L2015		

Kent McMillin President 12/14/21