State of GA, Healthcare Facility Regulation Division (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ B. WING PCH009781 09/02/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1460 SOUTH JOHNSON FERRY ROAD **DUNWOODY PLACE PERSONAL CARE HOME** ATLANTA, GA 30319 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) A 000 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 803 A 803 111-8-62-.08(2)(a) Administration. 11/13/2020 1. Staff Education & Training SS=K Executive Director and/or designee will The administrator or on-site manager of each ensure that staff will continue to personal care home must do the following: receive education and training on the (a) Ensure that the policies and procedures are following upon hire date and quarterly effective and enforced to support the health and safety of the residents. thereafter: abuse, neglect, and exploitation, importance of listening carefully This RULE is not met as evidenced by: to residents' concerns >>>>Based on record review and staff interview c. their responsibility to promptly and email, the administrator failed to ensure that report to their supervisor all the policies and procedures were enforced to resident concerns and any cosupport the health and safety of the residents for 1 of 4 sampled residents (Resident #1). Findings worker who they may reason to include: believe is misappropriating residents' personal property and A review of the facility's incident report submitted valuables to the Department on 8/4/20 showed an d. Retaliation for good faith allegation of a financial theft from Resident #1. reporting is prohibited 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 State of GA Inspection Report

IER REPRESENTATIVE'S SIGNATURE LABORATORY DIRECTOR'S OR PROVIDE

five Director

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State of C	A, Healthcare Facility	Regulation Division			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		MPLETED
		D011000704	B. WING		0/00/0000
		PCH009781	B. 111110		9/02/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
			TH JOHNSON I		
DUNWOO	DY PLACE PERSONAL (CARE HOME		ERRI ROAD	
		ATLANTA,	GA 30319		
(X4) ID		ATEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE DATE
TAG	REGULATORT OR E	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
			-		
A 803	Continued From page	÷ 1	A 803		
				2. Resident Education & Reminders/	12/16/2020
		ent #1's bank card on 8/4/20,		_	14 16/2020
	time unknown. The er	mail further showed that the		Security of Valuables	
	charges were made a	t two different stores at a		Executive Director will ensure that	I
	local shopping mall in	the vicinity of the facility.		residents will receive education on the	i l
				following via resident council meetings	
	A review of the facility	's policies and procedures		and in written memo from Executive	
		ghts showed residents were			1 1
	to be free from menta			Director:	
		ect and exploitation. The		a. Importance of using locked	
		at each resident had the		drawers/safes to keep their valuabl	es
		control his or her own		safe and to keep their locked drawe	
				-	13
	personal property and			out of plain sight	
	immediate living quar	iers.		b. Assistance with purchasing safes	
			1	and/or other appropriate security	
		n 8/20/20 at 1:00 p.m., Staff		item to protect valuables	,
	A stated the facility wa	as informed of financial theft		-	
	that involved Residen	t #1's bank card. Staff A		c. Community provision of placing	
**	stated that the Power	of Attorney (POA) of	ŧ	valuables in designated safe place	
	Resident #1 stated th	at between 7/2020 and		until resident requests access to	
	8/2020, there were tw	o (2) unauthorized		stored items	
	transactions in the an	nount of \$643.84, and		d. Upon resident request lockboxes w	.u
	\$451.93 charged to the	ne card. Staff A stated that			
		e from the location of each		installed in their unit	
		ed and the video footage			
		ew. Staff A stated that the		3. Monitoring of staff access to the	08/05/2020
	only policy and proce	*		community	00109/2020
	implemented was to d		1	Community	
		ed their valuable items to be		Executive and/or designee will ensure	
	_			_	
		afe by the facility. Staff A		that all employees will be issued key	
		020, he/she was asked to		fobs for them gain access to the	
		age that was in GG custody	1	building. This will improve community's	1
	and was unable to identifity the individual that		1	ability to track employees' entry into	
	charged the purchase	es to Resident #1's card.		the building	
				the building	
	This violation was pre	eviously cited on 7/10/20.			
A2512	111-8-62- 25/1\/h\ Su	pporting Residents' Rights.	A2512		
SS=K	111-0-0223(1)(11) 00	pporting residence ragines.			
55 1	Each regident has the	right to be free from			
	Each resident has the	sudur to be use upun	1		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		PCH009781	B. WING		09/02/2020
NAME OF D	ROVIDER OR SUPPLIER	QTDEET A	DDRESS, CITY, STAT	E ZIR CODE	
NAIVIL OF F	ROVIDEN ON SOFFEIEN		UTH JOHNSON F		
DUNWOO	DY PLACE PERSONAL O	CARE HOME	A, GA 30319	ERRI ROAD	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
A2512	Continued From page	2	A2512		
	right to be free from a or chemical restraints from isolation, corpora	on. Each resident has the ctual or threatened physical and the right to be free all or unusual punishment the daily functions of living,	w		
	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:				
	dated 8/2/20, at 1:07 presponded to the facility with Staff E who stated #1 informed him/her or charges on the bank of report showed that Rewas provided to the fac(2) unauthorized transfamount of \$1095.77. Officer attempted to interest the incident and the reward could not provide his/her fiances. The resuggested to Resident closer to him/her or to location. The report shade with FF via phore #1 finances and all of closed. The report furthe second incident of this facility, the first be report showed that the	inforcement (LE) report o.m., showed an officer ity for a fraud call. LE met de that the POA of Resident if the unauthorized financial card of Resident #1. The esident #1 bank statement incility, and there were two fractions made for a total. The report showed that the terview Resident #1 about esident appeared confused any information about export showed that the officer it #1 to keep his/her purse secure it in an enclosed anowed that contact was now who handled Resident Resident #1 account were there showed that this was finance theft in a month at sing case 20-003432. The exact was charged at two wo different shopping malls.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING:		(X3) DATE SURVEY COMPLETED	
		PCH009781	B, WING		09/0	2/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
DUNWOO	DY PLACE PERSONAL C	CARE HOME	UTH JOHNSON F A, GA 30319	FERRY ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
A2512	Continued From page A review of an email r Staff A showed that \$4 charged and posted of 8/4/20, time unknown charges were made a local shopping mall. A review of the 8/4/20 for Resident #1 showed the \$1095.77 charge to the \$1095	eceived on 8/21/20 from 451.93 and \$643.84 were in Resident #1 card on . The email showed that the t two different stores at in a 20 bank transaction reported that the banks reversed to a zero balance. Resident #1, admitted oses of depression, r active of bladder. In 8/20/20 at 1:00 p.m., Staff as informed of financial theft t #1 bank card. Staff A of Attorney (POA) of at between 7/2020 and to (2) charges for \$643.84 were unauthorized on card and there were no charges were made. Staff A deo footage and the video for his/her review. Staff A	A2512		RIATE	DATE
	video footage from bo	20, he/she reviewed the the locations that the card able to identify the individual s on Resident #1 card.		a a		
	B stated that he/she w med-tech. Staff B state were to pass medicati exit the room if the res additional assistance.	Staff B stated he/she was tesident #1 card and had				

State of GA Inspection Report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		PCH009781		B. WING		09/0	2/2020
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA	•		
DUNWOO	DY PLACE PERSONAL O	CARE HOME	1460 SOUT ATLANTA,	H JOHNSON F GA 30319	FERRY ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
A2512	During an interview of stated that he/she red 2020 credit card state unauthorized charges other charge was \$45 staff or resident was a #1's card and he/she transactions. FF state fraudulent transaction reimbursed the charge FF stated that this wa Resident #1 had his/h and he/she closed outstated that Resident #8/1/20 but the time of listed. During an interview or C stated that he/she v facility. Staff C stated witnessed a resident vout in plain sight. Staff never witnessed another resident personal item be reported immediate	eived Resident # ment and noticed , one for \$643.84 1.93. FF stated t authorized to use informed the facil d that he/she rep s to the bank and es on Resident #' s the second time er card stolen at t Resident #1 acc t's card was use the transactions of 1.9/1/20 at 11:47 vorked the third si that he/she has r valuable items or f C stated that he ner staff search the s and if witnesse	1's August I two (2) and the hat no Resident ity of card orted the I the bank I's card. Ithis facility ounts. FF I d on were not a.m., Staff hift at the liever jewelry left /she has iru a d, it would	A2512	DEFICIENCY)		
	stated that the facility and Resident's Rights management.	held a mandatory	meeting				
	During an interview or stated that he/she was the theft. GG stated the was viewed from the leand the facility was ur individual that used Rethat the facility was ur and when and how Rethat the/she to obtain an arrest was	s assigned to invent on 8/10/20 vide ocations of each nable to identity the esident #1 card. (hable to identify the sident #1 card we had insufficient each	estigate eo footage purchase ne GG stated ne person as stolen. evidence				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTR	514	IDENTITION	TON NOMBER.	A BUILDING:			VII ZETED	
		PCH009	781	B. WING			9/02/2020	
NAME OF PROVIDER OR S	SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
I DUNWOODY DIACE PERSONAL CARE HOME				TH JOHNSON I GA 30319	FERRY ROAD			
	CH DEFICIENC	ATEMENT OF DEFI Y MUST BE PRECE LSC IDENTIFYING II	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
was ongoi spoke with unable to card was a second the incident w. During an D stated the theft occur that the stated the Resident # resident varied about the confused a or concern back". Stated the advised Resident # secured lo stated that many card not want secured in Resident # had cance of how Resecured we facility. Stated ongoing at	in Resident is state when seen. GG seet of Resident interview of the affiname the affinament affi	ted that he/she #1 and the resi was the last tire stated that this ent #1 card and ding. In 9/1/20 at 5:16 heard from other third shirt. Staff at was mention about two monto passed medicanever witnessed is left out in plant of the passed medicanever witnessed in 9/2/20 at 3:10 filed a report with the passed with Red the resident and the passed in have to that Resident and the passed it was the back of the Staff E stated that move the pure the card that the staff E stated that it cards in his/heard. Staff E stated it cards in his/heard.	dent was me his/her was the d the prior 8 p.m., Staff er staff that f D stated med by other ths ago. Staff tion to ed any of the ain sight. 6 p.m., Staff th the local esident #1 appeared d no emotions o pay this #1 showed kept and the ed door that mat GG rse to a more afused. Staff E to state how allet and did t were d although mer purse, FF ated that plans mg to be and the ion was	A2512				

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State of 0	3A, Healthcare Facility	Regulation Division					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	:	A, BUILDING:		COMPLETED	
		PCH009781		B. WING		09/02/2020	
			TDEET 4000		TE JID CODE		
NAME OF PI	ROVIDER OR SUPPLIER			RESS, CITY, STA			
DUNWOO	DY PLACE PERSONAL O	:ARE HOME			FERRY ROAD		
			TLANTA, G				_
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		εl
TAG		SC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPE		
					DEFICIENCY)		
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State of GA Inspection Report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
	PCH009781	B. WING		07/10/2020
NAME OF PROVIDER OR SUPPLIER DUNWOODY PLACE PERSONAL OF	:ARE HOME	DRESS, CITY, STATE TH JOHNSON FE , GA 30319		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
A 000 Opening Comments. >>> The purpose of investigate intake # G The investigation was	•	A 000	EXHIBIT IS	
personal care home n (a) Ensure that the po	on-site manager of each nust do the following: licies and procedures are I to support the health and	A 803	1. Staff Education & Training Executive Director and/or desirensure that staff will continue receive education and training following upon hire date and of thereafter:	to on the
and email, the admini the policies and proce support the health and	t as evidenced by: I review and staff interview strator failed to ensure that dures were enforced to d safety of the residents for nts (Resident #1). Findings		 a. abuse, neglect, and explo b. importance of listening catoresidents' concerns c. their responsibility to proper to their supervisor resident concerns and an worker who they may real believe is misappropriation 	mptly all y co- uson to
to the Department on allegation of financial report showed a bank \$500.00 cash advance one (1) on 6/7/20 from machine (ATM). The amount charged on the The report further should and an investign A review of the facility for Resident Bill of Reshould be free from from and physical abuse, repolicy also showed the right to use, keep and	theft from Resident #1. The statement with three (3) es, two (2) on 6/6/20 and an automated teller report showed that the total ne bank card was \$1,500.00.		residents' personal propervaluables d. Retaliation for good faith reporting is prohibited	rty and
State of GA Inspection Report ABORATORY DIRECTOR'S OR PROVIDERS STATE FORM	SUPPLIER REPRESENTATIVE'S SIGNATUR		Executive Director	(X6) DATE) 0 10 00 If continuation sheet 1 of 6

STATE FORM

State of GA, Healthcare Facility Regulation Division

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State of GA, Healthcare Facility Regulation Division (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING PCH009781 07/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1460 SOUTH JOHNSON FERRY ROAD **DUNWOODY PLACE PERSONAL CARE HOME** ATLANTA, GA 30319 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID COMPLETE (ÉACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A 803 A 803 Continued From page 1 12/16/2020 2. Resident Education & Reminders/ personal property and possessions in the Security of Valuables immediate living quarters. Executive Director will ensure that During an interview on 6/29/20 at 8:30 a.m., Staff A stated the facility was informed of financial theft residents will receive education on the that involved Resident #1's bank card. Staff A following via resident council meetings stated that the Power of Attorney (POA) of and in written memo from Executive Resident #1 told him/her that between 6/6/2020 and 6/7/2020, there were five (5) \$500.00 ATM a. Importance of using locked withdrawals from a local bank and there were no drawers/safes to keep their valuables times given when the withdrawals from the ATM safe and to keep their locked drawers were made. Staff A stated that the bank informed the facilty that a video footage from the ATM was out of plain sight available for review. Staff A stated that on b. Assistance with purchasing safes 6/18/2020, he/she reviewed the video footage and/or other appropriate security and identified the individual that made the cash item to protect valuables withdrawals from the ATM as Staff D. Staff A c. Community provision of placing stated that Staff D was terminated on 6/23/20 at valuables in designated safe place 6:30 a.m. until resident requests access to Cross reference to 2512 stored items d. Upon resident request lockboxes will A2512 111-8-62-.25(1)(h) Supporting Residents' Rights A2512 installed in their unit SS=J Each resident has the right to be free from 3. Monitoring of staff access to the 08/05/2020 mental, verbal, sexual and physical abuse, community neglect and exploitation. Each resident has the right to be free from actual or threatened physical Executive and/or designee will ensure or chemical restraints and the right to be free that all employees will be issued key from isolation, corporal or unusual punishment and interference with the daily functions of living, fobs for them gain access to the such as eating or sleeping. building. This will improve community's ability to track employees' entry into the building 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:

PRINTED: 11/17/2020 FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING PCH009781 07/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1460 SOUTH JOHNSON FERRY ROAD **DUNWOODY PLACE PERSONAL CARE HOME** ATLANTA, GA 30319 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A2512 l Continued From page 2 A2512 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

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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

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.

any additional information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		PCH009781	B_ WING		07/10/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
DUNWOO	DY PLACE PERSONAL C	CARE HOME	OUTH JOHNSON TA, GA 30319	FERRY ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
A2512			A2512			
	charged on the bank of	showed that the total amount card was \$2,518.15 and the ot list the exact times of				
		20 bank transaction report ed that the bank reimbursed esident.				
	A stated the facility was that involved the bank A stated that the POA that between 6/6/2020 five (5) \$500.00 ATM bank and there were r	n 6/29/20 at 8:30 a.m., Staff as informed of financial theft card of Resident #1. Staff of Resident #1 told him/her and 6/7/2020, there were withdrawals from a local no times given for the ATM				
	never asked the facilit belongings and that the residents' personal be request. Staff A stated facilty that a video foo	tated that Resident #1 had by to store his/her personal he facility had a safe for elonging, used only upon that the bank informed the stage was available for a release the video to the				
12	police. Staff A stated to reviewed the video for identified the individual as Staff D. Staff A stat a.m., Staff D was term	hat on 6/18/2020, he/she otage from the ATM, and all that made the withdrawals led that on 6/23/20 at 6:30 hinated for violating the		<u></u>		
	he/she was unable to how Staff D received t confirmed that Staff D 6/5/20 to 6/9/20. Staff	ocedures. Staff A stated that determine when, where, or the bank card, but worked at the facility from f A stated that the police and notified of the incident and		2		
	an internal investigation During an interview or stated that he/she reco	on was initiated. n 6/29/20 at 12:31 p.m., GG eived the June 2020 bank #1, and noticed there were				

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		COMPL	
		PCH009781	B. WING		07 <i>l</i> ·	10/2020
	ROVIDER OR SUPPLIER DY PLACE PERSONAL O	CARE HOME 1460 SC	ADDRESS, CITY, STATE OUTH JOHNSON FE 'A, GA 30319			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
A2512	realized there were fix GG stated that the ch 6/6/2020 and 6/7/202! Resident #1 had a ze the total amount chard \$2518.15.00. GG stated \$18.15 for the five (5) he/she notified Staff A GG stated that he/she transactions to the bareimbursed for the chapolice were notified at card for Resident #1. During an interview of B stated that he/she was caregiver. Staff B stated that he/she was caregiver. Staff B stated that he/she work at the facility, and the resident's personal belonging ar checked on every two D stated that he/she be facility on 1/14/2020, was terminated on 6/2 Staff D stated that Stausing Resident #1 barand the transactions was the position of the chapolic existed that he/she resident withdrawals with Resistated that no officer him/her about the incinot been arrested. Staff requently provided care.	ve (5) \$500.00 transactions. arges were made between 0 and before the charges ro balance. GG stated that ged on the card was ed that the bank charged withdrawal fees and that of the ATM cash advances. e reported the fraudulent ink and Resident #1 was arges. GG stated that the ind that he/she kept the bank on 6/30/20 at 3:15 p.m., Staff vorked the second shift as a ed that he/she had seen elonging left out while at d that he/she never touched ing. Staff B stated that bout a theft of a resident's ind that the residents were of hours. on 6/30/20 at 4:20 p.m., Staff began employment at the Staff D stated that he/she 23/2020, reason unknown. off A accused him/her of onk card for cash withdrawals were caught on video. Staff bever made cash advance dent #1's bank card. Staff D or detective had contacted dent, and that he/she had aff D stated that he/she	A2512			

State of GA Inspection Report

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FORM APPROVED State of GA, Healthcare Facility Regulation Division STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: B. WING PCH009781 07/10/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1460 SOUTH JOHNSON FERRY ROAD **DUNWOODY PLACE PERSONAL CARE HOME** ATLANTA, GA 30319 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PRFFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A2512 Continued From page 5 A2512 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.

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