STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015032	A. Building B. Wing	08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Foley	1701 North Alston Street Foley, AL 36535

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41930 Based on interviews, review of the facility's Abuse, Neglect, Misappropriation, Exploitation Policy, Resident Identifier (RI) #1's medical record, and the facility's investigation file, the facility failed to ensure RI #1 was not abused by Employee Identifier (EI) #4, a Certified Nursing Assistant (CNA) on 7/1/2021. On 7/1/2021 around 2:00 PM, EI #3, a CNA witnessed EI #4, a CNA hit RI #1. EI #4 was then witnessed to restrain the resident by holding RI #1's arms to his/her chest. When the resident asked EI #4 to stop, EI #4 spanked (struck) the resident's hands several times as if he/she was a child. EI #4 was overheard telling the resident, You ain't stronger than me old (man/lady). This deficient practice placed RI #1, one of four sampled residents reviewed for abuse, in immediate jeopardy, as the situation was likely to cause serious injury, harm, impairment, or death. On 8/26/2021 at 7:12 PM, the facility's Administrator, Director of Nursing, Assistant Director of Nursing and a Corporate staff member were given a copy of the Immediate Jeopardy (IJ) template and notified of the finding of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation, F600. Findings include: The facility's Abuse, Neglect, Misappropriation, Exploitation Policy with an effective date of January 2019, documented, Purpose: To prohibit and prevent abuse, . in accordance with Federal and State Laws. Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Mental abuse: is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation . Physical Abuse: Includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior . RI #1 was readmitted to the facility on [DATE]. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015032	A. Building B. Wing	08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Foley	1701 North Alston Street Foley, AL 36535

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/5/2021, the facility submitted an allegation of physical abuse to the State Survey Agency regarding RI #1. According to the report, . At 7:49 am on 7/5/2021, (EI #3) reported to DNS (Director of Nursing Service) that on 7/1/2021 (EI #4) popped/spanked (RI #1) on the hand and was holding (him/her) down . The facility's INVESTIGATION TEMPLATE dated 7/14/2021, documented, . Investigative Summary: . On 7/5/2021, the Administrator and DNS spoke with (EI #3), CNA. She stated on 7/1/2021, (EI #4) asked her to come assist with providing care to (RI #1). She stated after she entered the room, (EI #4) spanked (RI #1) on the hand several times and was holding (him/her) down saying you ain't stronger than me old (man/lady). The Administrator asked (EI #3) to demonstrate how (EI #4) held (RI #1) down. (EI #3) crossed the Administrator's arms over her chest and pressed down not allowing the Administrator to move. On 7/13/2021, the Administrator spoke with (EI #3). She stated that (RI #1) was hitting out and saying stop prior to (EI #4) spanking (his/her) hands and restraining (him/her). The Director of Nursing (DNS) completed a skin assessment on (RI #1) and found 4 small brown discolored (round in shape) to the (r) (right) forearm and one discolored area (round in shape) on the (L) (left) wrist . It is the determination of this facility that the bruising noted on (RI #1's) forearm and wrist were consistent with the timeline and actions reported by CNA (EI #3). This Allegation was Substantiated . In an interview on 8/3/2021 at 2:48 PM, EI #3, a CNA was asked about the incident between RI #1 on EI #4. According to EI #3, EI #4 asked her to come into RI #1's room to assist her with the resident's bed bath. When RI #1 cursed at and became combative with EI #4, EI #4 told RI #1 that she was not stronger than her and then EI #4 held RI #1 down. EI #3 stated as she stood against the wall, she didn't know why this was happening. EI #3 stated while EI #4 held RI #1's arm against the resident's chest, EI #4 stated, I am stronger than you, old (man/lady). EI #4 then popped RI #1 on his/her hand first. Then EI #4 turned RI #1 over and shoved the resident in the direction of EI #3. When asked how EI #4 popped RI #1, EI #3 stated with an open hand, multiple times. When asked how the resident responded after being popped, EI #3 stated RI #1 didn't say anything else. When asked if what she observed was abuse, EI #3 said yes. When asked what kind of abuse, EI #3 replied, physical and mental. EI #3 was asked what the mental abuse was, and she stated it was EI #4 hollering at RI #1 and what she said. In a telephone interview on 8/4/2021 at 1:03 PM, EI #4, a CNA denied abusing RI #1 on 7/1/2021. The DIVERSICARE PROGRESSIVE DISCIPLINE FORM for EI #4 indicated the CNA's employment with the facility was terminated on 7/16/2021 for a Category 1 Violation: 1.1 Patient/resident abuse . The form further documented, . Summary of Incident: Team Member used unnecessary force while providing care to a resident . During an interview on 8/5/2021 at 8:40 AM, EI #1, the Administrator acknowledged that she was the facility's Abuse Coordinator. When asked how she became aware of the incident between RI #1 and EI #4, EI #1 stated on 7/5/2021, it was reported to her by the DNS, EI #2 and she and EI #2 both went into the office to talk with EI #3. According to EI #1, EI #3 stated EI #4 held RI #1's hands to his/her chest, to keep the resident from moving and EI #3 stated, You ain't stronger than me old (man/lady). EI #1 stated the allegation of abuse was substantiated based on the bruising to the resident. (continued on next page)

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Diversicare of Foley	1701 North Alston Street Foley, AL 36535

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #1's Shower Sheet dated 7/5/2021 completed by EI #2, the DON documented Bruise on top (L) (left) wrist 4 small brown discolored areas to (R) (right) forearm (L) wrist Bruise is blue in color and approx (approximately) 2cm (centimeter) & 2m (meter) round. ********** According to the facility's TIMELINE, the following corrective actions were implemented: . 7/5/2021 - (EI #4) WAS INTERVIEWED AND SUSPENDED IMMEDIATELY AFTER INCIDENT WAS REPORTED. SKIN ASSESSMENT COMPLETED ON (RI #1). 7/6/2021 - INCIDENT INVOLVING (RI #1) WAS DISCUSSED IN DAILY CONNECT MEETING. 7/6 - 7/13/2021 - INVESTIGATION WAS CONDUCTED. 7/14/2021 - FOLLOW-UP WAS SUBMITTED TO ADPH (Alabama Department of Public Health). CONTACTED (EI #4) TO COME IN AND DISCUSS OUTCOME OF INVESTIGATION. APPT SET FOR 7/16/2021. 7/16/2021 - CNA (EI #4) WAS TERMINATED. 7/16/2021 - PROGRESSIVE DISCIPLINE AND ONE TO ONE TRAINING WITH (EI #3) ON WHAT CONSTITUTES ABUSE AND REPORTING ABUSE PER CMS (Centers for Medicare & Medicaid Services) GUIDELINES WAS COMPLETED. 7/16/2021 - IN-SERVICE TRAINING ON HOW TO CARE FOR (RI #1), INCLUDING INTERVENTIONS AND APPROACHES ON HANDLING AGGRESSIVE BEHAVIORS WAS DONE WITH CNA'S (CNAs) AND NURSES. ********** After review of the facility's corrective action plan, investigation file, in-service/education records, Quality Assurance plan, and resident and staff interviews, the facility implemented corrective actions from 7/5/2021 to 7/16/2021, thus immediate jeopardy past non-compliance was cited. This deficiency was cited as a result of complaint/report number AL00041451.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Diversicare of Foley	1701 North Alston Street Foley, AL 36535

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41930 Based on interviews, review of the facility's Abuse, Neglect, Misappropriation, Exploitation Policy, the In-Service Training Record, the facility's assignment sheets and Employee Identifier (EI) #4's time sheet, the facility failed to ensure EI #3, a Certified Nursing Assistant (CNA) implemented two of seven components of the facility's abuse policy. On 7/1/2021 around 2:00 PM, EI #3, a CNA witnessed EI #4, a CNA hit Resident Identifier (RI) #1. EI #4 was then witnessed to restrain the resident by holding RI #1's arms to his/her chest. When the resident asked EI #4 to stop, EI #4 spanked (struck) the resident's hands several times as if he/she was a child. EI #4 was overheard telling the resident, You ain't stronger than me old (man/lady). EI #3 had been previously trained on the facility's abuse policy and procedures; however, EI #3 failed to identify the incident as abuse and immediately report the allegation to the facility's Abuse Coordinator. Because of these failures, EI #4, a CNA, was not removed from direct resident care and suspended as directed by the facility's policy. These deficient practices placed RI #1; one of four sampled residents reviewed for abuse, in immediate jeopardy, as the situation was likely to cause serious injury, harm, impairment, or death. On 8/26/2021 at 7:12PM, the facility's Administrator, Director of Nursing, Assistant Director of Nursing and a Corporate staff member were given a copy of the Immediate Jeopardy (IJ) template and notified of the finding of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation, F607. Findings include: The facility's Abuse, Neglect, Misappropriation, Exploitation Policy with an effective date of January 2019, documented, Purpose: To prohibit and prevent abuse, . in accordance with Federal and State Laws . 1. Protection First and foremost the resident/patient will be immediately assessed and removed from any potential harm. Examine the resident for any sign of injury, including a physical assessment or psychosocial assessment if indicated . If the suspected perpetrator is a team member, the Administrator/Director of Nursing or designee shall place the team member on immediate investigator suspension while completing the investigation . 5. Identification If actual or alleged violation occurs the resident will immediately be assessed and removed from any potential harm (as applicable). Education provided assists team members in identifying abuse . Education provided assists team members in identifying different types of abuse - mental/verbal abuse, . physical abuse, . 7. Reporting/Response Alleged violations/violations will be reported to the Administrator, designee immediately. Immediately reporting all alleged violations to the Administrator, designee, state agency, adult protective services and to all other required agencies within specified timeframes . On 7/1/2021 around 2:00 PM, EI #3, a CNA witnessed EI #4, a CNA hit RI #1. EI #4 was then witnessed to restrain the resident by holding RI #1's arms to his/her chest, this caused the resident not to be able to move. When the resident asked EI #4 to stop, EI #4 spanked (struck) the resident's hands several times as if he/she was a child. EI #4 was overheard telling the resident, You ain't stronger than me old (man/lady). After EI #3 consulted with someone outside of the facility, she finally reported the allegation of abuse to the facility's Director of Nursing (DON) on 7/5/2021. EI #4, who was in the facility working was immediately removed from the facility and placed on suspension pending the results of the investigation. Refer to F600 (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 8/3/2021 at 2:48 PM, EI #3, a CNA was asked about the incident between RI #1 and EI #4. According to EI #3, EI #4 asked her to come into RI #1's room to assist her with the resident's bed bath on 7/1/2021 around 2:00 PM. When RI #1 cursed at and became combative with EI #4, EI #4 told RI #1 that she was not stronger than her and then EI #4 held RI #1 down. EI #3 stated as she stood against the wall, she didn't know why this was happening. EI #3 stated while EI #4 held RI #1's arm against the resident's chest, EI #4 stated, I am stronger than you, old (man/lady). EI #4 then popped RI #1 on his/her hand first. Then EI #4 turned RI #1 over and shoved the resident in the direction of EI #3. When asked how EI #4 popped RI #1, EI #3 stated with an open hand, multiple times. When asked how the resident responded after being popped, EI #3 stated RI #1 didn't say anything else. When asked if what she observed was abuse, EI #3 said yes. When asked what kind of abuse, EI #3 replied, physical and mental. EI #3 was asked what the mental abuse was, and she stated it was EI #4 hollering at RI #1 and what she said. EI #3 was asked if she did or said anything during the incident. EI #3 replied, she did not. EI #3 acknowledged that two days later she reported what she saw to EI #2, the DON. When asked why she did not report the incident when it first happened, EI #3 stated at the time, she knew it should be reported but she didn't think it was abuse. When asked, at what point did she realize it was abuse, EI #3 stated it was after she got home and realized EI #4 had spanked RI #1 like a child, that she felt it was abuse. EI #3 explained that it bothered her over the next couple of days and she mentioned it to someone not affiliated with the facility, who told that it was abuse. During an interview on 8/4/2021 at 4:53 PM, EI #2, the DON was asked about the incident with RI #1. According to EI #2, as she was at the font doing temperatures on 7/5/2021, EI #3, a CNA approached her and stated she was leaving because of the way EI #4, a CNA, treats the residents. EI #2 stated she took EI #3 into her office to ask her what happened. It was at this time, EI #3 informed EI #2 that EI #4 had held RI #1 down during care and told the resident, you are not stronger than me old (man/lady). EI #2 stated she pulled EI #4 from patient care, had her to write a statement and sent her home (suspended). EI #2 also had EI #3 write a statement. Then EI #2 informed the Administrator, EI #1. When asked when did EI #3 report the incident occurred, EI #2 stated she said it happened on Thursday (7/1/2021). When asked why she (EI #3) waited to inform someone, EI #2 replied that she asked EI #3 and she stated she didn't know. EI #2 stated she reminded EI #3 that she had just gone through orientation, where abuse and neglect was discussed and that she was supposed to report it immediately. According to EI #2, EI #3 acknowledged the recent abuse and neglect training. When asked did EI #3 follow the facility's abuse policy, EI #2 said no because she did not report it immediately. EI #2 was asked how she participated in the investigation. EI #2 replied, she suspended EI #4, disciplined EI #3 and conducted a body audit (assessment) of RI #1. During the body audit, EI #2 stated RI #1 had discoloration on the top of both hands and a blue, quarter-size bruise on the left wrist. EI #2 stated this bruise was fairly new because of the color; it appeared to be about a day or two old. EI #2 stated there were four other smaller old discolored areas that were brown in color on the top of the resident's right forearm. According to EI #2 these discolored areas were consistent of someone holding RI #1 down. When asked if EI #4 followed the facility's abuse policy, EI #2 said she did not. EI #2 explained that EI #4 used unnecessary force which would fall under physical abuse. According to the facility's IN-SERVICE TRAINING RECORD, EI #3, a CNA received Abuse Neglect Misappropriation education on 6/17/2021. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 8/5/2021 at 8:40 AM, EI #1, the Administrator acknowledged she was the facility's Abuse Coordinator. When asked how she became aware of the incident between RI #1 and EI #4, EI #1 stated on 7/5/2021, it was reported to her by the DON, EI #2, and she and EI #2 both went into the office to talk with EI #3, a CNA. According to EI #1, EI #3 stated EI #4, a CNA, held RI #1's hands to his/her chest, to keep the resident from moving and EI #3 stated, You ain't stronger than me old (man/lady). EI #1 stated the allegation of abuse was substantiated based on the bruising to the resident. EI #1 was asked when did the incident occur. EI #1 replied, according to EI #3 it happened on 7/1/2021. When asked why there was a delay in reporting the incident, EI #1 stated that was a good question. EI #1 stated the CNA, EI #3 indicated to her that she was confused, shocked and not sure what she saw was abuse until after she talked with someone else. EI #1 stated EI #3 had received training on hire on reporting abuse. EI #1 acknowledged that EI #3 did not follow the facility's policy on abuse, when she did not immediately report the allegation of abuse. When asked what the potential harm was for not reporting an allegation of abuse immediately, EI #1 stated the incident could happen again. After reviewing time sheet, EI #1 stated EI #4 worked in the facility on 7/1/2021, 7/3/2021, 7/4/2021 and 7/5/2021 until 9:30 AM. According to the facility's assignment sheet for 7:00 AM to 3:00 PM shift on 7/1/2021, EI #4, a CNA was assigned to care for residents who resided in rooms 309 to 315. During the 7:00 AM to 3:00 PM shift on 7/3/2021, EI #4 was assigned to care for residents who resided in room [ROOM NUMBER] to 316. During the 7:00 AM to 3:00 PM shift on 7/4/2021, EI #4 was assigned to care for residents who resided in room [ROOM NUMBER] to 315. On 7/5/2021 during the 7:00 AM to 3:00 PM shift, EI #4 was assigned to care for residents who resided in room [ROOM NUMBER] to 316. EI #4's time sheet indicated on 7/1/2021, EI #4 clocked in for work at 8:47 AM and clocked out at 3:00 PM. On 7/3/2021, EI #4 clocked in for work at 7:04 AM and clocked out at 3:00 PM. On 7/4/2021, EI #4 clocked in for work at 7:08 AM and clocked out at 3:00 PM. On 7/5/2021, EI #4 clocked in for work at 7:12 AM. The handwritten note on the bottom written by EI #1, the Administrator documented Team member (EI #4) . left at approx. (approximately) 9:30 am (on 7/5/2021). ********** According to the facility's TIMELINE, the following corrective actions were implemented: . 7/5/2021 - (EI #4) WAS INTERVIEWED AND SUSPENDED IMMEDIATELY AFTER INCIDENT WAS REPORTED. SKIN ASSESSMENT COMPLETED ON (RI #1). 7/6/2021 - INCIDENT INVOLVING (RI #1) WAS DISCUSSED IN DAILY CONNECT MEETING. 7/6 - 7/13/2021 - INVESTIGATION WAS CONDUCTED. 7/14/2021 - FOLLOW-UP WAS SUBMITTED TO ADPH (Alabama Department of Public Health). CONTACTED (EI #4) TO COME IN AND DISCUSS OUTCOME OF INVESTIGATION. APPT SET FOR 7/16/2021. 7/16/2021 - CNA (EI #4) WAS TERMINATED. 7/16/2021 - PROGRESSIVE DISCIPLINE AND ONE TO ONE TRAINING WITH (EI #3) ON WHAT CONSTITUTES ABUSE AND REPORTING ABUSE PER CMS (Centers for Medicare & Medicaid Services) GUIDELINES WAS COMPLETED. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7/16/2021 - IN-SERVICE TRAINING ON HOW TO CARE FOR (RI #1), INCLUDING INTERVENTIONS AND APPROACHES ON HANDLING AGGRESSIVE BEHAVIORS WAS DONE WITH CNA'S (CNAs) AND NURSES. ********** After review of the facility's corrective action plan, investigation file, in-service/education records, Quality Assurance plan, and resident and staff interviews, the facility implemented corrective actions from 7/5/2021 to 7/16/2021, thus immediate jeopardy past non-compliance was cited. This deficiency was cited as a result of complaint/report number AL00041451.