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	08/04/2018

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 - Some	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** 32557 Based on interviews, review of a complaint received by the Alabama State Survey Agency, the facility's Abuse Policy and medical record reviews, the facility failed to ensure Resident Identifier (RI) #71 and RI #85 were free from abuse perpetrated by RI #49 and RI #84, residents who reside on the secured Alzheimer's Care Unit (Dementia unit) of the facility. On 4/28/2018, RI #49 was observed to willfully push RI #71 down, causing the resident to fall, cry and scrape the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During the first shift on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed RI #85's face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 on one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, RI #49 forcefully pushed another resident, RI #71, down causing this resident to fall. Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor. On 5/9/2018, RI #84 was observed by staff to forcefully and intentionally push RI #71 down to the floor, which rendered RI #71 unconscious. These deficient practices affected RI #71 and RI #85, two of six sampled residents reviewed for abuse; and placed these residents in immediate jeopardy for serious injury, harm or death. This failure also had the potential to affect the remaining 26 residents who resided on the facility's Alzheimer's Care Unit. On 8/1/2018 at 8:35 PM, the facility's Administrator, Director of Nursing Service, Director of Clinical Operations and Senior Director of Clinical Operations were notified of the findings of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation, F600. Findings include: On 7/18/2018, the Alabama State Survey Agency received a complaint, in which the caller reported resident on resident altercations on the dementia unit. The caller alleged, RI #84 pushed RI #71 and RI #85 down. The dates and specific information was not known by the caller. Then on 5/25/2018, RI #49 followed another resident into their room and pushed the resident's head into the wall. (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
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's Abuse Policy with an effective date of February 2017, documented . Definitions Abuse means the willful (the individual must have acted deliberately, not that they must have intent to injury or harm) infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish . Physical abuse includes hitting, slapping, punching and kicking . POLICY STATEMENT It is the policy of the center to take appropriate steps to prevent the occurrence of abuse . 1) RI #49 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia with Behavioral Disturbance. RI #49's Admission Minimum Data Set (MDS) with an assessment reference date of 4/25/2018, indicated RI #49 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #49 displayed inattention, delusions, physical behavioral symptoms directed toward others, rejection of care and wandering during this assessment period. RI #71 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia without Behavioral Disturbance. RI #71's Quarterly MDS with an assessment reference date of 4/19/18, indicated RI #71 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #71 displayed physical behavioral symptoms directed toward others during this assessment period. RI #71's Progress Notes dated 4/28/2018 at 6:44 PM written by Employee Identifier (EI) #4, a Licensed Practical Nurse (LPN) documented . (RI #71) was standing in hallway at porch area in front of (another resident) rollator and (another resident) was saying get get out of here . (RI #49) got up and pushed this Resident (RI #71) down. (RI #71) landed in sitting position and scraped (his/her) side of (his/her) back . (RI #71) sitting on floor crying with back against chair/rollator - abrasion noted to upper left side of back . In a telephone interview on 7/30/2018 at 10:48 AM, EI #4, a LPN acknowledged she witnessed the incident when RI #49 pushed RI #71 down on 4/28/2018. EI #4 stated she was standing at the medication cart and there was about four to five residents in a semi-circle in the porch area and RI #49 was standing. As RI #71 walked into the middle of the semi-circle, RI #49 forcefully pushed RI #71 to get the resident out of the group; RI #71 fell to the floor. According to EI #4, RI #49 didn't intend to make RI #71 fall but RI #49 did intentionally push RI #71. When asked if she considered this incident abuse, EI #4 said yes. In an interview on 7/31/2018 at 1:04 PM, EI #2, the DNS was asked to define abuse. EI #2 defined abuse as the willful act of confinement, causing harm, pain, or mental anguish. EI #2 further explained that willful meant the action was deliberate, but did not necessarily mean there was an intent to cause harm or injury. When asked if it would be considered abuse, if a staff member witnessed one resident push another resident down, EI #2 said yes. During an interview on 7/31/2018 at 3:53 PM, EI #1, the Administrator, acknowledged the incident that occurred on 4/28/2018, when RI #49 pushed RI #71 down, should have been considered as abuse. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2) RI #85 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia without Behavioral Disturbance. RI #85's Admission MDS with an assessment reference date of 4/6/2018, indicated RI #85 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #85 displayed wandering behavior daily during this assessment period and the wandering significantly intruded on the privacy of the activities of others. RI #49 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia with Behavioral Disturbance. RI #49's Admission MDS with an assessment reference date of 4/25/2018, indicated RI #49 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #49 displayed inattention, delusions, physical behavioral symptoms directed toward others, rejection of care and wandering during this assessment period. RI #49's Progress Notes titled Behavior Charting dated 5/2/2018 at 11:21 PM, written by EI #5, a LPN, documented Describe Behavior/Mood: Resident (RI #49) sitting in chair on porch area when lower cognitive Resident (RI #85) entered porch area and began to try and attempt to climb into the chair beside (RI #49). (RI #49) began yelling at resident Go away Just go away. The other resident (RI #85) continued to climb up in chair . CNA (Certified Nursing Assistant) (EI #6) was in the process of entering porch area to attempt to redirect resident that was climbing in chair out of area when the higher functioning resident (RI #49) slapped the lower functioning resident (RI #85) in the face . In a telephone interview on 7/30/2018 at 4:11 PM, EI #5, a LPN was asked to describe what she observed between RI #49 and RI #85 on 5/2/2018. EI #5 stated RI #85 was attempting to crawl up in a chair and RI #49 slapped RI #85. When asked to describe the slap, EI #5 stated RI #49 held his/her arm up, bent the elbow, rotated the arm and slapped RI #85. EI #5 stated she assessed RI #85 and did not see any redness. According to EI #5, she thought this incident was abuse, but after talking with the DNS (EI #2) and EI #3, the Director of Clinical Operations (DCO), they advised her otherwise. EI #5 said they told her it appeared not to be a slap but more of a tap on the face. EI #5 stated she was told she should have used different wording in her charting (documentation). EI #5 acknowledged that she did not report this incident to the Administrator or DNS. During an interview on 7/31/2018 at 1:04 PM, EI #2, the DNS stated she was not called about the incident that occurred between RI #49 and RI #85 on 5/2/2018. EI #2 stated she discovered the documentation during a chart review. EI #2 acknowledged the incident should have been handled as an allegation of abuse. During an interview on 7/31/2018 at 3:53 PM, EI #1, the Administrator, acknowledged a resident slapping another resident met the definition of physical abuse. 3) RI #84 was readmitted to the facility on [DATE]. RI #84 has a medical history to include diagnoses of Dementia with Behavioral Disturbance, Adjustment Disorder with Depressed Mood, Anxiety Disorder, and Altered Mental Status. RI #84's Quarterly MDS with an assessment reference date of 4/6/2018, indicated RI #84 was severely impaired in cognitive function with a Brief Interview for Mental Status (BIMS) of five. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #71 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia without Behavioral Disturbance. RI #71's Quarterly MDS with an assessment reference date of 4/19/18, indicated RI #71 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #71 displayed physical behavioral symptoms directed toward others during this assessment period. RI #71's Progress Notes dated 5/9/2018 at 4:00 PM, written by EI #10, a Registered Nurse (RN), indicate on 5/9/2018, RI #71 fell and was momentarily unconscious after the fall. The progress noted indicated RI #71 had a hematoma on left forehead. In a telephone interview on 7/30/2018 at 12:32 PM, EI #10, a RN, was asked about the 5/9/2018 incident. When asked what she witnessed, EI #10 said she only saw a hand and half of a forearm. She said when she got to RI #71 after the fall, RI #84 was standing over RI #71. EI #10 said the hand and arm she saw appeared to be that of RI #84, based on the shape of the hand and the fingernails. EI #10 said she saw the hand of RI #84 forcefully make contact with RI #71's chest, close to the shoulder. EI #10 said it was forceful. During an interview on 7/31/2018 at 1:04 PM, EI #2, the DNS acknowledged she became aware of the 5/9/2018 incident immediately after it had occurred. When asked how she became aware, EI #2 stated she thought EI #10 reported it to her. When asked what was said, EI #2 said she was told RI #84 had caused RI #71 to fall and hit (his/her) head. When asked what caused the fall, EI #2 said she was told the residents were on the porch and RI #84 pushed RI #71 in an attempt to move RI #71 away from RI #84. EI #2 was asked if this action met the definition of abuse. EI #2 replied, yes it did. In an interview on 7/31/2018 at 3:53 PM, EI #1, the Administrator, agreed the incident that occurred on 5/9/2018 between RI #71 and RI #84 was a situation of potential abuse. 4) RI #85 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia without Behavioral Disturbance. RI #85's Admission MDS with an assessment reference date of 4/6/2018, indicated RI #85 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #85 displayed wandering behavior daily during this assessment period and the wandering significantly intruded on the privacy of the activities of others. RI #49 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia with Behavioral Disturbance. RI #49's Admission MDS with an assessment reference date of 4/25/2018, indicated RI #49 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #49 displayed inattention, delusions, physical behavioral symptoms directed toward others, rejection of care and wandering during this assessment period. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #49's Progress Notes titled Behavior Charting dated 5/25/2018 1:48 PM, written by EI #7, a LPN, documented . Describe Behavior/Mood: Agitation. Restlessness. Aggression noted towards lower cognitive Residents What was the resident doing prior to or at the time of behavior/mood: CNA (EI #8) reported this Resident pushed (RI #85's) face into wall. Staff attempted to separate Residents. This Resident (RI #49) continues to target (RI #85). (RI #85) wanders in an area, (RI #49) will yell at other Resident (RI #85) and attempt to push, slap, and hit (RI #85) . In an interview on 7/25/2018 at 9:43 AM, EI #8, a CNA was asked to describe the incident that occurred on 5/25/2018 between RI #49 and RI #85. EI #8 said she was exiting the dining room with EI #9, another CNA, when she saw RI #85 standing in the doorway of the bathroom across the hall. RI #49 then went up to RI #85 and punched RI #85 twice in the back, then took RI #85 by the back of the head and slammed RI #85's face into the metal door facing. EI #8 said as she and EI #7 were approaching the residents, RI #49 slammed the bathroom door on RI #85. In an interview on 7/25/2018 at 2:59 PM, EI #9, a CNA was asked to describe the incident that occurred on 5/25/2018 between RI #49 and RI #85. EI #9 said she saw RI #49 hit RI #85 in the back twice, and described RI #49 as angry at the time of the altercation. EI #9 said this incident occurred in RI #49's room, at the bathroom doorway. RI #49 then pushed RI #85's face into the door facing, and when RI #85 stumbled into the bathroom, RI #49 slammed the door on RI #85. In a telephone interview on 7/30/2018 at 11:28 PM, EI #7, a LPN was asked about the incident that occurred on 5/25/2018 between RI #49 and RI #85. According to EI #7, she was notified of the incident by EI #8, a CNA. EI #8 reported that RI #49 had yelled at RI #85, pushed RI #85's head into the wall and tried to close the door on RI #85. EI #7 said after she completed a body audit of RI #85, she went down the hall in an attempt to find either the DNS, EI #2 or the Administrator, EI #1. EI #7 stated she found EI #2, the DNS and asked her to come to the Dementia unit because there was a problem. According to EI #7, she reported to EI #2, that she had been told by EI #8 (CNA) who was present to witness the notification, that RI #49 had yelled at RI #85, pushed RI #85's head into the wall and tried to slam a door on RI #85. EI #7 stated when EI #2 came to the Dementia unit, she completed a body audit of RI #85 and re-oriented RI #49. When asked if abuse was discussed, EI #7 said no. When asked to define abuse, EI #7 stated there were several different forms of abuse. Physical abuse was a form and it included hitting, kicking, pushing, slapping and punching. When asked if she considered this incident between RI #49 and RI #85 as abusive, EI #7 said yes. During an interview on 7/31/2018 at 1:04 PM, EI #2, the DNS acknowledged the incident that occurred on 5/25/2018 between RI #49 and RI #85 was abuse. In an interview on 7/31/2018 at 3:53 PM, EI #1, the Administrator, agreed the incident involving RI #49 and RI #85 that occurred on 5/25/2018 was an incident of potential abuse and should have been investigated by the facility as such. 5) RI #71 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia without Behavioral Disturbance. RI #71's Quarterly MDS with an assessment reference date of 4/19/18, indicated RI #71 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #71 displayed physical behavioral symptoms directed toward others during this assessment period. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #49 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia with Behavioral Disturbance. RI #49's Admission MDS with an assessment reference date of 4/25/2018, indicated RI #49 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #49 displayed inattention, delusions, physical behavioral symptoms directed toward others, rejection of care and wandering during this assessment period. RI #49's Progress Notes dated 5/25/2018 at 7:28 PM, written by EI #4, a LPN, documented . Resident (RI #49) in another Resident's room (number) and (RI #71) was ambulating down hallway and started to enter room (number) and this Resident (RI #49) started pushing Resident (RI #71) back resulting in (RI #71) falling in doorway . (RI #49) has dementia with behavior disturbances - (RI #49) easily agitated and wanders in unit going in other Residents room taking their belongings - Hx (history) of aggressive behavior since admission with staff unable to redirect . Resident alert with confusion - aggravated and angry at this moment - yelling at staff and other Resident's around. and slapping at this nurse making contact multiple times . An interview was conducted with EI #4, a LPN on 7/30/2018 at 10:48 AM. EI #4 was asked about the incident that occurred on 5/25/2018 when RI #49 pushed RI #71 down causing RI #71 to fall. EI #4 said she was walking down the hall to take another resident their medication. EI #4 said she saw RI #71 at the end of the hallway but then RI #71 turned around and started to go into a resident's room. EI #4 said she then heard RI #49 say, get out of here then she witnessed RI #49 forcefully push RI #71 down. EI #4 stated she was within three feet of the residents when the incident occurred. EI #4 further stated RI #49 was supposed to be on one-to-one staff supervision at this time, due to an incident that occurred earlier in the day, but no staff was present with RI #49 when RI #49 forcefully pushed RI #71 down to the floor. When asked if this altercation between RI #49 and RI #71 was abuse, EI #4 said yes. Both EI #2, the DNS and EI #1, the Administrator stated in interviews on 7/31/2018 at 1:04 PM and 7/31/2018 at 3:53 PM respectively, stated the altercation between RI #49 and RI #71 that occurred on 5/25/2018 was abuse. 6) RI #85 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia without Behavioral Disturbance. RI #85's Admission MDS with an assessment reference date of 4/6/2018, indicated RI #85 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #85 displayed wandering behavior daily during this assessment period and the wandering significantly intruded on the privacy of the activities of others. RI #49 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia with Behavioral Disturbance. RI #49's Admission MDS with an assessment reference date of 4/25/2018, indicated RI #49 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #49 displayed inattention, delusions, physical behavioral symptoms directed toward others, rejection of care and wandering during this assessment period. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #49's Progress Notes dated 6/26/2018 at 2:30 PM, written by EI #10, a RN, documented . This resident (RI #49) and another resident (RI #85) were pushing each other and both fell . This was witnessed and (RI #49) landed in a sitting position. (RI #49) did not hit (his/her) head . During an interview on 7/30/2018 at 12:32 PM, EI #10, a RN was asked about the progress note dated 6/26/2018. EI #10 stated she was in the office when one of the CNAs came and told her that two residents were on the floor. EI #10 stated she went down to the sensory room and observed RI #49 and RI #85 on the floor, with EI #11, the Physical Therapist (PT) present. According to EI #10, EI #11 stated she was working with another resident when RI #49 came in and sat near her. Then RI #85 came and put (his/her) hand on RI #49's arm. The residents then started to push each other and fell to the floor. When asked if she considered this abuse, EI #10 said no based on what she had been told by the facility but now she would say it was abuse because pushing, hitting and kicking was abuse. In an interview on 7/31/2018 at 8:31 AM, EI #11, the PT was asked about the incident that occurred between RI #49 and RI #85 on 6/26/2018. EI #11 said the incident occurred in the sensory room on the ACU. EI #11 said she had taken another resident into the sensory room to complete an evaluation and RI #49 followed them into the room and sat down. EI #11 said RI #85 also came into the room, waked over to RI #49 and then pushed RI #49 in the upper arm. EI #11 further explained RI #85's hand was open, and the force of the push/nudge moved RI #49's upper body. She said this appeared to irritate RI #49 and RI #49 turned and shoved RI #85 the same way. EI #11 said both residents began shoving each other back and forth, and before she could get to them both RI #49 and RI #85 fell to the floor. EI #11 said she would consider the altercation she witnessed to be abuse. Both EI #2, the DNS and EI #1, the Administrator stated in interviews on 7/31/2018 at 1:04 PM and 7/31/2018 at 3:53 PM respectively, stated the altercation between RI #49 and RI #85 that occurred on 6/26/2018 was abuse. ********** On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented Abuse failure to ensure two residents residing on the Dementia unit were free from abuse from other residents: All center staff in-serviced regarding Facility Abuse Policy to include definitions of Abuse, Examples of Abuse, and Interventions to deal with aggressive and/or catastrophic reactions of resident/patients. Implementation of the abuse policy, identification and reporting of Abuse as well as Investigating Abuse. Inclusion of the interpretive guidelines for resident to resident altercations began 8/02/2018 at 1:00PM and will continue until all staff have received training. One hundred twelve of 128 staff members trained on as of 8/03/2018. Additional trainings scheduled for 8/4/2018 to in-service PRN staff, facility has no agency staff. No staff member will be allowed to work without the required training after 8/04/2018. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI# 49 and RI# 84 behavior care plans were reviewed/revised by the Senior DCO on 8/02/2018 to address behaviors and to provide interventions to protect lower cognitive residents from resident to resident altercations similar to those which occurred on 4/28/2018, 5/02/2018, 5/09/2018, 5/25/2018 X 2, and 6/26/2018. New interventions are relayed to the direct care staff by direct one on one in-service by the interim ACU programming manager, LPN. RIs #84 and 49 will be referred to Wellness Solutions for psychiatric evaluation to be conducted on 8/03/2018. Medical evaluation of RI# 49 was conducted on 07/28/2018 by attending physician and on 07/30/2018 by medical director. RI# 85 and 71 will also be evaluated by Wellness Solutions on 08/03/2018. Notes from evaluations are pending receipt from provider. Care plans of RIs will be reviewed for needed changes/ updates after receipt of Wellness Solutions notes. Sr Director of Clinical Operations and RN will review past 30 day documentation of residents currently residing on the Dementia Unit to identify documented behaviors to identify risk for being abused and perpetrating abuse by 8/03/2018. Upon identification of documented behaviors care plans will be reviewed, revised to include interventions to reduce/eliminate to prevent re-occurrences with input from the direct care staff. All allegations reported to state agency beginning on 07/29/2018. On 08/04/2018, Sr Director of Clinical Operations and RN reviewed records (Nurses notes, behavioral notes, weekly notes, daily notes) over the past 30 days to determine if other incidents occurred that should have been reported. Any instances of abuse identified, Interim Administrator will follow and implement reporting per facility Abuse policy and procedure. Interviews will conducted beginning 8/04/2018 with staff and alert residents for identification of any unreported allegations from May 2018 forward for any resident to resident altercations or abuse of any type. Ongoing programming developed and tailored to individual resident preferences to be offered and implemented by the dementia care staff over all shifts after receiving training by the Interim ACU programing manager. Start training roster 08/04/2018 on the day shift. The interim administrator started on 08/03/2018. She was trained on abuse policies/regulations by Sr Director of Clinical Operations on 08/03/2018. The Sr Director of Clinical Operations assumed the Interim DNS role on 08/03/2018. Both will serve as the Abuse coordinators for the center. Abuse Coordinators Names and Phone numbers are posted throughout the facility. ********** After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F600 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00035795.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32557 Based on interviews, medical record review and the facility's Abuse Policy, the facility failed to: 1) intervene and correct situations to prevent further abuse (Prevention); 2) ensure the Director of Nursing Service (DNS) reported allegations of abuse to the Administrator, who serves as the Abuse Coordinator. Furthermore, these allegations of abuse were not reported to the State survey agency (Reporting); 3) ensure the DNS and Administrator identified situations of resident/resident altercations as abuse (Identification); 4) protect Resident Identifier (RI) #71, RI #85 and other residents from abuse perpetrated by RI #49 and RI #84 (Protection); and 5) investigate these allegations of physical abuse (Investigation). On 4/28/2018, RI #49 was observed to willfully push RI #71 down, causing the resident to fall, cry and scrape the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During the first shift on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed RI #85's face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 on one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, RI #49 forcefully pushed another resident, RI #71 down, causing this resident to fall. Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor. On 5/9/2018, RI #84 was observed by staff to forcefully and intentionally push RI #71 down to the floor, which rendered RI #71 unconscious. These deficient practices affected Resident Identifier (RI) #71 and RI #85, two of six sampled residents reviewed for abuse; and placed these residents in immediate jeopardy for serious injury, harm or death. These failures also had the potential to affect the remaining 26 residents who resided on the facility's Alzheimer's Care Unit. On 8/1/2018 at 8:35 PM, the facility's Administrator, Director of Nursing Service, Director of Clinical Operations and Senior Director of Clinical Operations were notified of the findings of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation, F607. Findings include: Prevention The facility's Abuse Policy with a effective date of February 2017, documented . Prevention Team members are required to report incidents of suspected abuse, neglect or misappropriation of resident/patient property without fear of reprisal . The Administrator/Director of Nursing shall identify, intervene and correct situations in which abuse, neglect or misappropriation of resident/patient property are more likely to occur . Refer to F600 (continued on next page)

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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 - Some	An interview was conducted with EI #2, the Director of Nursing Service (DNS), on 7/31/2018 at 1:04 PM to discuss the six resident-on-resident altercations that occurred on the facility's Alzheimer's Care Unit (ACU). EI #2 was asked what actions did the facility take to prevent further abuse after RI #49 willfully push RI #71 down on 4/28/2018. EI #2 replied, she didn't know what was done. When asked what corrective actions the facility took after the abuse that occurred on 5/2/2018 when RI #49 slapped RI #85. EI #2 stated there were no change in interventions to prevent another incident. EI #2 was asked what actions the facility took after RI #84 forcefully and intentionally pushed RI #71 down, rendering RI #71 unconscious on 5/9/2018. EI #2 replied, an assessment of RI #71 to include neurological checks were performed on RI #71 because the resident was either difficult to arouse or unconscious and the physician and family were notified. When asked what corrective actions the facility took after RI #49 yelled at RI #85, pushed RI #85's head into a wall and tried to slam a door on the resident on 5/25/2018, EI #2 said she redirected RI #49 and called the physician to restart RI #49's Depakote medication. According to Mosby's 2017 Nursing Drug Reference with a copyright date of 2017, Depakote is an anticonvulsant medication used to treat various types of seizure disorders. Depakote can also be used to treat manic episodes related to bipolar disorder (manic depression) and to prevent migraine headaches. EI #2 was asked what corrective actions/steps were taken to prevent further abuse after RI #49 forcefully pushed RI #71 down causing RI #71 to fall on 5/25/2018. EI #2 explained, if she had it to do all over again, she would follow the facility's policy. EI #2 stated she didn't do what she should have known to do and took full responsibility for it; no corrective actions were taken. When asked what actions were taken after it was observed RI #49 and RI #85 were pushing each other and both residents fell on [DATE], EI #2 replied other than looking at both residents to make sure they were okay, she did not know what was done. Reporting The facility's Abuse Policy with a effective date of February 2017, documented . Reporting All alleged violations involving mistreatment, neglect, abuse or exploitation including injuries of unknown source and misappropriation of resident/patient property are reported immediately to the Administrator/Director of Nursing and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). Immediately means as soon as possible: 1. Any allegation of abuse within two hours and 2. Any neglect, mistreatment, exploitation or misappropriation of resident property without serious injury within 24 hours The results of all investigations must be reported by the Administrator/Director of Nursing to the appropriate state agency, as required by state law, within five (5) working days of the alleged violation . Refer to F600 (continued on next page)

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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 - Some	An interview was conducted with EI #2, the DNS, on 7/31/2018 at 1:04 PM to discuss the six resident-on-resident altercations that occurred on the facility's Alzheimer's Care Unit (ACU). EI #2 was asked when did she become aware that RI #49 willfully pushed RI #71 down on 4/28/2018. EI #2 stated she didn't recall being made aware of this incident. When it was explained to EI #2 that EI #4, LPN, stated she notified her within 30 minutes of the occurrence, EI #2 stated she certainly believed EI #4, she just didn't recall being notified. EI #2 stated she considered the occurrence abuse and should have reported it. When asked if she reported the allegation of abuse to the Administrator, EI #2 said no. EI #2 was asked when did she become aware that RI #49 had slapped RI #85 on 5/2/2018. EI #2 stated she was not notified of this. EI #2 explained that she discovered this incident during a chart review. When asked if the allegation of abuse was reported, EI #2 said no. EI #2 explained that she should have reported it but didn't. EI #2 was asked when she became aware that RI #84 forcefully and intentionally pushed RI #71 causing the resident to be rendered unconscious on 5/9/2018. EI #2 answered that she was immediately notified of the incident by the nurse, EI #10. When asked if the incident met the definition of abuse, EI #2 said yes. When asked if the allegation of abuse was reported to the Administrator and State survey agency, EI #2 said no. EI #2 was asked when she became aware of the incident that occurred on 5/25/2018 when RI #49 yelled at RI #85, pushed RI #85's head into a wall and tried to slam a door on RI #85. EI #2 replied, she was immediately notified. When asked was the incident considered an allegation of abuse, EI #2 said yes. When asked if she reported to the Administrator this allegation of abuse, EI #2 said she did not recall. EI #2 was asked when she became aware of the incident that occurred on 5/25/2018 when RI #49 forcefully pushed RI #71 down causing the resident to fall. EI #2 replied that she was notified later the night of 5/25/2018. When asked was this incident considered abuse, EI #2 said yes. EI #2 explained that she did not report this allegation of abuse to the Administrator or the State survey agency; EI #2 stated she was out of town. Lastly, EI #2 was asked when she became aware of the incident that occurred on 6/26/2018 when RI #49 and RI #85 were pushing each other and fell . EI #2 replied, she was pretty sure she was made aware right when it happened. When asked if considered this occurrence abuse, EI #2 said yes. When asked if the allegation of abuse was reported, EI #2 said no. Identification The facility's Abuse Policy with a effective date of February 2017, documented . Definitions Abuse means the willful (the individual must have acted deliberately, not that they must have intent to injury or harm) infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish . Physical abuse includes hitting, slapping, punching and kicking. It also includes controlling behavior through corporal punishment . Identification Incidents of alleged violations shall be reviewed by QAPI (Quality Assurance Process Improvement) for detection of patterns or trends . Refer to F600 During an interview on 7/30/2018 at 7:51 AM, EI #2, the DNS, stated for the last [AGE] years the facility did not have to report resident on resident altercations involving dementia patients. EI #2 stated she was aware of the regulatory changes that occurred in November (2017), but said the changes had not sunk in with her yet. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 7/30/2018 at 10:48 AM, EI #4, a LPN was asked if she considered the incidents that occurred on 4/28/2018 and 5/25/2018 when RI #49 willfully pushed RI #71 down, causing the resident to fall as abuse. EI #4 said yes. When asked if she reported to EI #2 that the incidents were abuse, EI #4 said no. EI #2 explained that the nursing staff was not supposed to tell the administrative staff whether or not it was abuse. They were tell them what happened and they (administrative staff) would make the determination whether or not it was abuse. During an interview with EI #10, a RN on 7/30/2018 at 12:32 PM, she stated she was told by EI #2, the DNS and EI #15, the Assistant Director of Nursing Service (ADNS) that it was not abuse if it was not malicious. EI #10 further stated that now since the State survey agency was in the facility, the facility has said it's abuse whether or not there was an intent to cause harm. In a telephone interview on 7/30/2018 at 4:11 PM, EI #5, a LPN was asked to describe what she observed between RI #49 and RI #85 on 5/2/2018. EI #5 stated RI #85 was attempting to crawl up in a chair and RI #49 slapped RI #85. When asked to describe the slap, EI #5 stated RI #49 held his/her arm up, bent the elbow, rotated the arm and slapped RI #85. When asked to define abuse, EI #5 said it was when someone intentionally or willfully intended to cause harm to someone. According to EI #5, she thought this incident was abuse, but after talking with the DNS (EI #2) and EI #3, the Director of Clinical Operations (DCO), they advised her otherwise. EI #5 said they told her it appeared not to be a slap but more of a tap on the face. EI #5 stated she was told she should have used different wording in her charting (documentation). During a follow-up interview on 7/31/2018 at 1:04 PM, EI #2, the DNS acknowledged she had asked the nursing staff to call her before they documented a resident's fall to ensure the staff was documenting objectively. EI #2 stated there was a lot of subjective documentation. When asked why the staff stated they had to communicate with you before documenting, to ensure the documentation avoided looking as though it was abuse, EI #2 said she didn't know why the staff would say that. EI #2 explained that she was confused about the facility's abuse policy and she didn't know. EI #2 stated she just wanted the staff to document what they saw and not what they felt. After review of the facility's policy, EI #2 stated she now knows each of the six resident-on-resident altercations should have been considered allegations of abuse. When asked if the allegations of abuse were reviewed by the facility's Quality Assurance committee for the detection of trends/patterns, EI #2 said no. When asked why not, EI #2 said the committee talked about the incidents as falls and not allegations of abuse. In an interview with the facility's Administrator, EI #1, on 7/31/2018 at 3:53 PM, he was asked about the resident-on-resident altercations that occurred on the facility's Alzheimer's Care Unit (ACU). EI #1 explained that he didn't understand those were allegations of abuse. EI #1 stated before the change in November (2017), there was more latitude to say whether something was intentionally done or not. In another interview with EI #2, the DNS on 8/1/2018 at 10:22 AM, she was asked what had staff been told about resident-on-resident abuse. EI #2 replied, she thought the facility missed that. EI #2 stated the facility focused more on exploitation rather than residents with dementia now being considered abuse. EI #2 explained she felt this is where she failed because she didn't stress that topic. EI #2 stated that part of the policy was not engrained in her thinking. Protection (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's Abuse Policy with a effective date of February 2017, documented . Protection If the circumstances require it, Administrator/Director of Nursing or designee shall remove a resident/patient suspected of being the subject of an alleged violation to an environment where the resident/patient's safety can be protected. * If the suspected perpetrator is another resident/patient, the Administrator/Director of Nursing or designee shall separate the resident/patients so they do not have access to each other until the circumstances of the alleged incident can be determined . RI #49 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia with Behavioral Disturbance. RI #49's Admission Minimum Data Set (MDS) with an assessment reference date of 4/25/2018, indicated RI #49 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #49 displayed inattention, delusions, physical behavioral symptoms directed toward others, rejection of care and wandering during this assessment period. On 4/28/2018, RI #49 was observed to willfully push RI #71 down, causing the resident to fall, cry and scrape the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During the first shift on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed RI #85 face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 on one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, RI #49 forcefully pushed another resident, RI #71, down, causing this resident to fall. Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor. Refer to F600 On 5/9/2018, RI #84 was observed by staff to forcefully and intentionally push RI #71 down to the floor, which rendered RI #71 unconscious. Refer to F600 An interview was conducted with EI #2, the DNS, on 7/31/2018 at 1:04 PM to discuss the six resident-on-resident altercations that occurred on the facility's Alzheimer's Care Unit (ACU). EI #2 was asked what actions did the facility take to protect RI #71 and other residents after RI #49 willfully pushed RI #71 down on 4/28/2018. EI #2 replied, she didn't know what was done. When asked what was done to protect RI #85 and other residents after the abuse that occurred on 5/2/2018 when RI #49 slapped RI #85. EI #2 stated there was nothing done. EI #2 was asked how the facility protected RI #71 and other residents after RI #84 forcefully and intentionally pushed RI #71 down, rendering RI #71 unconscious on 5/9/2018. EI #2 replied, an assessment of RI #71 to include neurological checks were performed on RI #71 because the resident was either difficult to arouse or unconscious and the physician and family were notified. When asked how the facility protected RI #85 and other residents after RI #49 yelled at RI #85, pushed RI #85's head into a wall and tried to slam a door on the resident on 5/25/2018, EI #2 said she redirected RI #49 and called the physician to restart RI #49's Depakote medication. EI #2 was asked how the facility protected RI #71 and other residents after RI #49 forcefully pushed RI #71 down causing RI #71 to fall on 5/25/2018. EI #2 explained, if she had it to do all over again, she would follow the facility's policy. EI #2 stated she didn't do what she should have known to do and took full responsibility for it; no corrective actions were taken. When asked how the facility protected other residents after it was observed RI #49 and RI #85 were pushing each other and both residents fell on [DATE], EI #2 replied other than looking at both residents to make sure they were okay, she did not know what was done. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Investigation The facility's Abuse Policy with a effective date of February 2017, documented . Investigation Anytime there is an allegation of abuse, . the center must report the alleged violation to the Administrator/Director of Nursing, the Chief Compliance Officer, and other officials, and also initiate an immediate investigation and prevent further potential abuse. Based on the investigation findings, the center will implement corrective actions to prevent recurrence. All investigations shall be conducted by the Administrator/Director of Nursing or subject matter expert unless there is a conflict of interest or they are implicated in the alleged violations. In the event an alleged violation occurs when none of these people are available, the manager in charge is responsible for initiating the investigation procedure unless there is a conflict of interest or the person is implicated in the alleged violations. The investigation shall include interviews of team members, visitors, resident/patients, volunteers and vendors who may have knowledge of the alleged incident. Factual information only should be documented, not assumptions, speculation or conclusions. Written statements from involved parties should not be requested as all information will be documented on the investigation form or a state required form. The documentation of the investigation shall be kept in a secure administrative file . The medical record should be reviewed to determine resident/patient's past history and condition and its relevance to the alleged violation. Federal law requires the center to have evidence of investigations of alleged violations. The investigation form or state required form shall be completed after the investigation is complete and provided to survey agencies when requested or required by state or federal law . Corrective Action The center shall make reasonable efforts to determine the cause of the alleged violation and take corrective action consistent with the investigation findings and to eliminate any ongoing dangers to the resident/patient or other resident/patients that may be affected. The Director of Nursing in conjunction with other clinicians shall initiate or revise a care plan to reflect the resident/patient's condition and measures to be taken to prevent recurrence, where appropriate. Appropriate steps shall be taken to prevent recurrence of the incident. This may include in-services or other measures as appropriate. The steps taken should be documented. Documentation All alleged violations shall be recorded. Copies of this form shall be kept in the center. Documentation in the medical record shall be made where necessary for continuity of care for the resident/patient. Separate incident reports or other written reports, when required by state law, shall be maintained and produced in accordance with state law. Refer to F600 In an interview with EI #2, the DNS on 7/31/2018 at 1:04 PM, to discuss the six resident-on-resident altercations that occurred on the facility's Alzheimer's Care Unit (ACU). When asked in there was an investigation into the allegation of abuse that occurred on 4/28/2018 between RI #49 and RI #71, EI #2 said no. When asked if there was an investigation into the allegation of abuse that occurred on 5/2/2018 between RI #49 and RI #85, EI #2 said she did not investigate it. EI #2 was asked if there was an investigation done into the allegation of abuse that occurred on 5/9/2018 between RI #71 and RI #84. EI #2 replied, she did not have a documented investigation. When asked if there was investigation into the allegation of abuse that occurred on 5/25/2018 between RI #49 and RI #85, EI #2 said no. When asked if there was an investigation into the allegation of abuse that occurred on 5/25/2018 between RI #49 and RI #71, EI #2 no. When asked why not, EI #2 said she was out of town and just did not do it. EI #2 stated she just didn't do what she was supposed to do and took full responsibility for it. EI #2 was asked if there was an investigation into the allegation of abuse that occurred between RI #49 and RI #85 on 6/26/2018. EI #2 answered no and explained she should have started an investigation immediately after being made aware of the incident. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/31/2018 at 3:35 PM, EI #1, the Administrator stated they were not in the formal investigative mode when they discovered these situations, so nothing was written down about them. When asked what an investigation into potential abuse should consist of, EI #1 said an investigation consisted of understanding the facts about what happened to accurately determine effective ways to prevent reoccurrences. EI #1 said witnesses should be interviewed, an observation of the area may be needed, and a review of the medical records. When asked why these allegations of abuse were not investigated, as specified in the facility's Abuse Policy, EI #1 said he didn't know. ********** On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented Implementation -- Failure of the Facility to follow the center Abuse Policy . Director of Clinical Education reviewed documentation to ensure all team members have completed Annual abuse training by 8/02/2018. All center staff provided group in-service education by the Sr Director of Clinical Operations regarding Facility Abuse Policy to include definitions of Abuse, Examples of Abuse, and Interventions to deal with aggressive and/or catastrophic reactions of resident/patients to include one to one monitoring to ensure resident protection and prevention of subsequent altercations and what to report and when. Implementation of the abuse policy to include identification and reporting of Abuse as well as Investigating Abuse. Inclusion of the interpretive guidelines for resident to resident altercations began 8/02/2018 at 1:00PM and will continue until all staff have received training. One hundred twelve of 128 staff members trained on as of 8/03/2018. Additional trainings scheduled for 8/4/2018 to in-service weekend staff working and PRN staff, facility has no agency staff. No staff member will be allowed to work without the required training after 8/04/2018. In-service education regarding Abuse identification and reporting to include the Interpretive Guidelines for resident to resident abuse of any type provided to the Administrator and DNS by the Sr Director of Clinical Operations on 8/02/2018 at 8:00AM. Training included Resident to Resident altercations involving residents with Dementia. Interim Administrator received abuse training by the Sr Director of Clinical Operations on 08/03/2018. All of the above referenced allegations have been reported to the state agency by the Administrator/Abuse Coordinator as of 8/02/2018. All investigations shall be conducted by the Interim Administrator/Director of Nursing. The above referenced allegations with the complete investigation of occurrences will be submitted to the state survey agency within the required 5 days of the report. The Administrator and DNS have been placed on Administrative leave pending investigation. The interim administrator started on 08/03/2018. She was trained on abuse policies/regulations by Sr Director of Clinical Operations on 08/03/2018. The Sr Director of Clinical Operations assumed the DNS role on 08/03/2018. Both will serve as the Abuse coordinators for the center. Abuse Coordinator Name and Phone numbers posted throughout the facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	********** After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F607 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00035795. 33413

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 32557 Based on interviews and review of the facility's Abuse Policy, the Director of Nursing Service (DNS) failed to report allegations of physical abuse to the Administrator, who serves as the Abuse Coordinator. Furthermore, these allegations of abuse were not reported to the State survey agency. On 4/28/2018, RI #49 was observed to willfully push RI #71 down, causing the resident to fall, cry and scrape the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During the first shift on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed RI #85's face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 on one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, RI #49 forcefully pushed another resident, RI #71 down, causing this resident to fall. Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor. On 5/9/2018, RI #84 was observed by staff to forcefully and intentionally push RI #71 down to the floor, which rendered RI #71 unconscious. This deficient practice affected RI #71 and RI #85, two of six sampled residents reviewed for abuse; and placed these residents in immediate jeopardy for serious injury, harm or death. This failure also had the potential to affect the remaining 26 residents who resided on the facility's Alzheimer's Care Unit. On 8/1/2018 at 8:35 PM, the facility's Administrator, Director of Nursing Service, Director of Clinical Operations and Senior Director of Clinical Operations were notified of the findings of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation, F609. Findings include: The facility's Abuse Policy with a effective date of February 2017, documented . Reporting All alleged violations involving mistreatment, neglect, abuse or exploitation including injuries of unknown source and misappropriation of resident/patient property are reported immediately to the Administrator/Director of Nursing and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). Immediately means as soon as possible: 1. Any allegation of abuse within two hours and 2. Any neglect, mistreatment, exploitation or misappropriation of resident property without serious injury within 24 hours The results of all investigations must be reported by the Administrator/Director of Nursing to the appropriate state agency, as required by state law, within five (5) working days of the alleged violation . Refer to F600 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with EI #2, the DNS, on 7/31/2018 at 1:04 PM to discuss the six resident-on-resident altercations that occurred on the facility's Alzheimer's Care Unit (ACU). EI #2 was asked when did she become aware that RI #49 willfully pushed RI #71 down on 4/28/2018. EI #2 stated she didn't recall being made aware of this incident. When it was explained to EI #2 that EI #4, LPN, stated she notified her within 30 minutes of the occurrence, EI #2 stated she certainly believed EI #4, she just didn't recall being notified. EI #2 stated she considered the occurrence abuse and should have reported it. When asked if she reported the allegation of abuse to the Administrator, EI #2 said no. EI #2 was asked when did she become aware that RI #49 had slapped RI #85 on 5/2/2018. EI #2 stated she was not notified of this. EI #2 explained that she discovered this incident during a chart review. When asked if the allegation of abuse was reported, EI #2 said no. EI #2 explained that she should have reported it but didn't. EI #2 was asked when she became aware that RI #84 forcefully and intentionally pushed RI #71 causing the resident to be rendered unconscious on 5/9/2018. EI #2 answered that she was immediately notified of the incident by the nurse, EI #10. When asked if the incident met the definition of abuse, EI #2 said yes. When asked if the allegation of abuse was reported to the Administrator and State survey agency, EI #2 said no. EI #2 was asked when she became aware of the incident that occurred on 5/25/2018 when RI #49 yelled at RI #85, pushed RI #85's head into a wall and tried to slam a door on RI #85. EI #2 replied, she was immediately notified. When asked was the incident considered an allegation of abuse, EI #2 said yes. When asked if she reported to the Administrator this allegation of abuse, EI #2 said she did not recall. EI #2 was asked when she became aware of the incident that occurred on 5/25/2018 when RI #49 forcefully pushed RI #71 down causing the resident to fall. EI #2 replied that she was notified later the night of 5/25/2018. When asked what this incident considered abuse, EI #2 said yes. EI #2 explained that she did not report this allegation of abuse to the Administrator or the State survey agency; EI #2 stated she was out of town. Lastly, EI #2 was asked when she became aware of the incident that occurred on 6/26/2018 when RI #49 and RI #85 were pushing each other and fell . EI #2 replied, she was pretty sure she was made aware right when it happened. When asked if considered this occurrence abuse, EI #2 said yes. When asked if the allegation of abuse was reported, EI #2 said no. ********** On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented Reporting: All center staff provided group in-service education by the Sr Director of Clinical Operations regarding Facility Abuse Policy to include definitions of Abuse, Examples of Abuse, and Interventions to deal with aggressive and/or catastrophic reactions of resident/patients to include one to one monitoring to ensure resident protection and prevention of subsequent altercations and what to report and when. Implementation of the abuse policy to include identification and reporting of Abuse as well as Investigating Abuse. Inclusion of the interpretive guidelines for resident to resident altercations began 8/02/2018 at 1:00PM and will continue until all staff have received training. One hundred thirty-five staff members trained on as of 8/04/2018. Facility has no agency staff. No staff member will be allowed to work without the required training after 8/04/2018. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	All identified allegations reported to state agency beginning on 7/29/2018. On 08/04/2018, Sr Director of Clinical Operations and Director of Nursing Services reviewed records (Nurses notes, behavioral notes, weekly notes, daily notes) over the past 30 days to determine if other incidents occurred that should have been reported. Any instances of abuse identified, Interim Administrator will follow and implement reporting per facility policy and procedure. The interim administrator started on 08/03/2018. She was trained on abuse policies/regulations by Sr Director of Clinical Operations on 08/03/2018. The Sr Director of Clinical Operations assumed the DNS role on 08/03/2018. Both will serve as the Abuse coordinators for the center. Abuse Coordinators Names and Phone numbers are posted throughout the facility. Sr Director of Clinical Operations will provide clinical oversight and monitoring of the reporting process. The Administrator received in-service education by the Sr Director of Clinical Operations on 8/02/2018 at 8:00AM. ********** After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F609 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00035795. 33413

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. 32557 Based on interviews and review of the facility's Abuse Policy, the facility failed to investigate allegations of abuse perpetrated by Resident Identifier (RI) #49 and RI #84, two cognitively impaired residents who reside on the facility's secure Alzheimer's Care Unit. On 4/28/2018, RI #49 was observed to willfully push RI #71 down, causing the resident to fall, cry and scrape the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During the first shift on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed RI #85's face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 on one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, RI #49 forcefully pushed another resident, RI #71 down, causing this resident to fall. Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor. On 5/9/2018, RI #84 was observed by staff to forcefully and intentionally push RI #71 down to the floor, which rendered RI #71 unconscious. This deficient practice affected RI #71 and RI #85, two of six sampled residents reviewed for abuse; and placed these residents in immediate jeopardy for serious injury, harm or death. This failure also had the potential to affect the remaining 26 residents who resided on the facility's Alzheimer's Care Unit. On 8/1/2018 at 8:35 PM, the facility's Administrator, Director of Nursing Service, Director of Clinical Operations and Senior Director of Clinical Operations were notified of the findings of immediate jeopardy in the area of Freedom from Abuse, Neglect, and Exploitation, F610. Findings include: Investigation (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's Abuse Policy with a effective date of February 2017, documented . Investigation Anytime there is an allegation of abuse, . the center must report the alleged violation to the Administrator/Director of Nursing, the Chief Compliance Officer, and other officials, and also initiate an immediate investigation and prevent further potential abuse. Based on the investigation findings, the center will implement corrective actions to prevent recurrence. All investigations shall be conducted by the Administrator/Director of Nursing or subject matter expert unless there is a conflict of interest or they are implicated in the alleged violations. In the event an alleged violation occurs when none of these people are available, the manager in charge is responsible for initiating the investigation procedure unless there is a conflict of interest or the person is implicated in the alleged violations. The investigation shall include interviews of team members, visitors, resident/patients, volunteers and vendors who may have knowledge of the alleged incident. Factual information only should be documented, not assumptions, speculation or conclusions. Written statements from involved parties should not be requested as all information will be documented on the investigation form or a state required form. The documentation of the investigation shall be kept in a secure administrative file . The medical record should be reviewed to determine resident/patient's past history and condition and its relevance to the alleged violation. Federal law requires the center to have evidence of investigations of alleged violations. The investigation form or state required form shall be completed after the investigation is complete and provided to survey agencies when requested or required by state or federal law . Corrective Action The center shall make reasonable efforts to determine the cause of the alleged violation and take corrective action consistent with the investigation findings and to eliminate any ongoing dangers to the resident/patient or other resident/patients that may be affected. The Director of Nursing in conjunction with other clinicians shall initiate or revise a care plan to reflect the resident/patient's condition and measures to be taken to prevent recurrence, where appropriate. Appropriate steps shall be taken to prevent recurrence of the incident. This may include in-services or other measures as appropriate. The steps taken should be documented. Documentation All alleged violations shall be recorded. Copies of this form shall be kept in the center. Documentation in the medical record shall be made where necessary for continuity of care for the resident/patient. Separate incident reports or other written reports, when required by state law, shall be maintained and produced in accordance with state law. Refer to F600 In an interview with EI #2, the DNS on 7/31/2018 at 1:04 PM, to discuss the six resident-on-resident altercations that occurred on the facility's Alzheimer's Care Unit (ACU). When asked in there was an investigation into the allegation of abuse that occurred on 4/28/2018 between RI #49 and RI #71, EI #2 said no. When asked if there was an investigation into the allegation of abuse that occurred on 5/2/2018 between RI #49 and RI #85, EI #2 said she did not investigate it. EI #2 was asked if there was an investigation done into the allegation of abuse that occurred on 5/9/2018 between RI #71 and RI #84. EI #2 replied, she did not have a documented investigation. When asked if there was investigation into the allegation of abuse that occurred on 5/25/2018 between RI #49 and RI #85, EI #2 said no. When asked if there was an investigation into the allegation of abuse that occurred on 5/25/2018 between RI #49 and RI #71, EI #2 no. When asked why not, EI #2 said she was out of town and just did not do it. EI #2 stated she just didn't do what she was supposed to do and took full responsibility for it. EI #2 was asked if there was an investigation into the allegation of abuse that occurred between RI #49 and RI #85 on 6/26/2018. EI #2 answered no and explained she should have started an investigation immediately after being made aware of the incident. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/31/2018 at 3:35 PM, EI #1, the Administrator stated they were not in the formal investigative mode when they discovered these situations, so nothing was written down about them. When asked what an investigation into potential abuse should consist of, EI #1 said an investigation consisted of understanding the facts about what happened to accurately determine effective ways to prevent reoccurrences. EI #1 said witnesses should be interviewed, an observation of the area may be needed, and a review of the medical records. When asked why these allegations of abuse were not investigated, as specified in the facility's Abuse Policy, EI #1 said he didn't know. ********** On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented Investigation: The investigations of above reported allegations are currently on-going and will be completed within the required time frame to the state agency. Reviewed/Revised care plans for identified RIs to include interventions to reduce/eliminate risk of resident to resident altercations/abuse by 8/02/2018 by Registered Nurses. All center staff provided group in-service education by the Sr Director of Clinical Operations regarding Facility Abuse Policy to include definitions of Abuse, Examples of Abuse, and Interventions to deal with aggressive and/or catastrophic reactions of resident/patients to include one to one monitoring to ensure resident protection and prevention of subsequent altercations and what to report and when. Implementation of the abuse policy to include identification and reporting of Abuse as well as Investigating Abuse. Inclusion of the interpretive guidelines for resident to resident altercations began 8/02/2018 at 1:00PM and will continue until all staff have received training. One hundred twelve of 128 staff members trained on as of 8/03/2018. Additional trainings scheduled for 8/4/2018 to in-service weekend staff working and PRN staff, facility has no agency staff. No staff member will be allowed to work without the required training after 8/04/2018. Training for staff who will be completing/ documenting/ tracking incidents. All investigation files will be maintained in the Interim Administrator's office. VP will oversee and review the investigation process and reporting via the company Red event reporting program. Red event reporting occurs when an event (abuse) has been identified, it is reported to the VP as a Red event and is reviewed on a conference call weekly with COO and VP of Clinical Operations. ********** After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F610 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00035795. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	33413

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32557 Based on interview and review of Resident Identifier (RI) #49's medical record, the facility failed to identify and address the behavioral health care needs of RI #49, a resident with repeated incidents of resident/resident abuse . On 4/28/2018, RI #49 was observed to willfully push RI #71 down, causing the resident to fall, cry and scrape the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During the first shift on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed RI #85's face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 on one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, RI #49 forcefully pushed another resident, RI #71 down, causing this resident to fall. Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor. Refer to F600 The facility further failed to ensure there was a policy/procedure/protocol that directed the staff on how to respond to behaviors and track and trend behaviors to ensure the resident's behavioral care plan was effective in meeting the needs of the resident. RI #49 had documented escalating behaviors; however, the staff responsible for behavior management, Employee Identifier (EI) #12, the Unit Manager/Memory Care Director, was not aware of any systems the facility had in place to monitor RI #49's behaviors. This deficient practice affected RI #49, one of 11 sampled residents reviewed for behaviors, and placed this resident in immediate jeopardy for serious injury, harm or death. This deficient practice had the potential to affect all 20 residents identified by the facility as having behavioral health needs. On 8/2/2018 at 5:08 PM, the facility's Regional [NAME] President was notified of the findings of immediate jeopardy in the area of Behavioral Health Services, F740. Findings include: RI #49 was admitted to the facility on [DATE] with an admitting diagnosis of Dementia with Behavioral Disturbance. RI #49 has a medical history to include diagnoses of Unspecified Psychosis and Restlessness and Agitation. RI #49's Admission Minimum Data Set (MDS) with an assessment reference date of 4/25/2018, indicated RI #49 was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #49 displayed inattention, delusions, physical behavioral symptoms directed toward others, rejection of care and wandering during this assessment period. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	RI #49's care plan titled Sometimes I show behavior symptoms/risks Becoming confused/cursing/pushing at staff and others, confrontational behavior and (of) lower cognitive residents . I also mimic the behavior of some of the lower cognitive residents initiated on 4/27/2018 and last revised on 6/22/2018, had a goal of Episodes of (my mimicking lower cognitive residents, and pushing staff and others), pushing, pulling on others, . will not interfere with the safety or well-being of myself or others thru my next review. The interventions listed were: During episodes of inappropriate behaviors, please re-direct me by approaching slowly and speaking to me in a calm and steady voice - trying to redirect me to an alternative activity or topic of discussion. Encourage me to participate in activities to give me something to focus on. Help me avoid situations and people that trigger inappropriate behaviors. Help me maintain a consistent daily routine. Notify my doctor if my behaviors interfere with my functioning and give meds as ordered. Offer me a quieter setting to help soothe me. On 4/28/2018, RI #49 was observed to willfully push RI #71 down, causing the resident to fall, cry and scrape the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During the first shift on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed RI #85's face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 on one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, RI #49 forcefully pushed another resident, RI #71 down, causing this resident to fall. Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor. Refer to F600 RI #49's behavior charting for the time period 4/1/2018 to 4/30/2018, indicated on 4/21/2018, RI #49 had threatening behavior; on 4/28/2018 RI #49 was pushing; and on 4/30/2018, RI #49 had abusive language. RI #49's behavior charting for the time period 5/1/2018 to 5/31/2018, indicated RI #49 displayed threatening behaviors on 5/2/2018, 5/3/2018, 5/19/2018, 5/20/2018, 5/23/2018 and 5/25/2018. RI #49 displayed pushing behaviors on 5/4/2018, 5/20/2018, 5/23/2018 and 5/25/2018. RI #49 was kicking/hitting on 5/5/2018, 5/18/2018, 5/20/2018, 5/21/2018, and 5/25/2018. RI #49 had three instances of grabbing, on 5/5/2018, 5/19/2018 and 5/20/2018. RI #49 used abusive language on 5/5/2018, 5/18/2018 and 5/25/2018. RI #49's behavior charting for the time period 6/1/2018 to 6/30/2018, indicated RI #49 displayed threatening behaviors on 6/8/2018, 6/9/2018, 6/14/2018, 6/17/2018, 6/22/2018, 6/24/2018 and 6/27/2018. RI #49 was pushing on 6/20/2018, 6/22/2018 and 6/26/2018. RI #49 was kicking/hitting on 6/8/2018, 6/19/2018, 6/22/2018, 6/24/2018 and 6/26/2018. RI #49 had one instance of grabbing on 6/24/2018. RI #49 used abusive language on 6/8/2018, 6/9/2018 and 6/26/2018. RI #49 had one instance of pinching/scratching/spitting on 6/22/2018. RI #49's behavior charting for the time period 7/1/2018 to 7/31/2018, indicated RI #49 had one instance of pushing on 7/5/2018 and one instance of threatening behavior on 7/26/2018. RI #49 was kicking/hitting on 7/5/2018, 7/10/218, 7/11/2018, 7/12/2018, 7/17/2018, 7/21/2018 and 7/28/2018. On 8/2/2018 at 9:00 AM , EI #2, the Director of Nursing Services (DNS) stated EI #12, the Unit Manager/Memory Care Director was responsible for overseeing behavior management on the facility's Alzheimer's Care Unit (ACU). (continued on next page)

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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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 8/2/2018 at 10:45 AM, EI #12, the Unit Manager/Memory Care Director, was asked how was behavior management addressed on the ACU. EI #12 stated there was not a truly focused program the facility was utilizing. When asked if the facility had a policy/procedure or protocol for behavior management, EI #12 said no. EI #12 was asked what system she utilized to track resident behaviors in an attempt to implement prevention techniques. EI #12 replied, there was not a system. EI #12 was asked, what behaviors RI #49 displayed on admission. EI #12 replied, RI #49 was exit seeking, so a wanderguard was placed. EI #12 acknowledged RI #49's behavior care plan was initiated on 4/27/2018. When asked what was done after RI #49 forcefully pushed another resident down on 4/28/2018, EI #12 said she didn't see anything that was done. When asked what was done after RI #49 was observed to slap another resident on 5/2/2018, EI #12 said the residents were separated and redirected. EI #12 commented I failed that situation, I really did my best. EI #12 explained that she had never reviewed RI #49's behavior charting. EI #12 said if she would have reviewed the behavior charting, it would have allowed her to see the information with the day and time, trends, who was working with the resident, etc When asked what was done after RI #49 yelled and physically assaulted RI #85 on 5/25/2018, EI #12 said she was not sure as she was on vacation. EI #12 commented, the resident's care plan was revised on 6/22/2018 with an intervention to notify the physician of behaviors that interfere with functioning, give medications as ordered and take resident to a quieter setting. When asked about RI #49's behaviors for the month of June, EI #12 said RI #49's behaviors were escalating. EI #12 then said the incidents involving RI #49 could have possibly been avoided and behaviors could have been decreased if RI #49's behaviors had been tracked. ********** On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented Behavior Management: Facility failed to have policy and procedure to instruct staff response on how to track and trend behaviors Facility RN reviewed and updated the behavior care plan for RI #49 on 08/02/2018. Other identified RIs care plans will be reviewed and updated by RN by 08/02/2018. Training for Dementia unit staff to be provided by Sr Director of Clinical Operations regarding updating care plans when incidents occur. Training to utilize Dementia Care Policy/ Guideline that includes proactive philosophies to enhance calm environment and minimize distressing behavioral expressions, education on Relias regarding managing of challenging behaviors, general approaches for those with dementia to understand behaviors and provide a safe environment. Post behavioral event tool will be used to determine root cause and is designed to understand the trigger of the behavior exhibited to assist with establishing appropriate interventions. Sr Director of Clinical Operations provided in-service education for all staff members beginning 8/3/2018 at 7:00AM on Dementia Care Guideline that includes proactive philosophies to enhance calm environment and minimize distressing behavioral expressions, General approaches for those with dementia to understand behaviors and provide a safe environment and the post behavioral event tool designed to understand the root cause or trigger of the behavior exhibited to help with establishing the correct intervention. Sr Director of Clinical Operations has completed 47 of 128 team members and has scheduled additional trainings on 8/4/2018 to educate the PRN and weekend staff. No other staff will work after 8/4/2018 until they have received the training. (continued on next page)

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	015032	A. Building B. Wing	08/04/2018

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 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Clinical team members, includes: Interim Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education, Unit Managers, will complete the post behavioral event tool during the daily clinical meeting for residents with documented behaviors to determine possible root cause of exhibited behaviors which contributed to the incident occurrence. Clinical team will then update care plan to address results of possible root cause beginning 8/4/2018. Interim Administrator will attend meetings with the clinical team to assure compliance. Impromptu in-servicing, small group discussion, increased oversight by management team (new ACU Programming Manager), collaboration of line staff in program development as well as implementation, more family involvement to individualize programs and plans of care for residents residing on the Dementia unit. ********** After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F740 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00035795. 33413

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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32557 Based on interviews and review of job description's, the facility administrative staff, to include Employee Identifier (EI) #1, the facility's Administrator, who is responsible for directing and overseeing the day to day operations of the facility and EI #2, the Director of Nursing Service (DNS), who manages the nursing department, failed to identify incidents of resident/resident altercations as abuse. They also failed to implement the facility's abuse policy and procedure and failed to ensure they educated the staff on the correct definition of abuse. These deficient practices affected Resident Identifier (RI) #71 and RI #85, two of six sampled residents reviewed for abuse; and placed these residents in immediate jeopardy for serious injury, harm or death. These failures also had the potential to affect the remaining 26 residents who resided on the facility's Alzheimer's Care Unit. On 8/1/2018 at 8:35 PM, the facility's Administrator, Director of Nursing Service, Director of Clinical Operations and Senior Director of Clinical Operations were notified of the findings of immediate jeopardy in the area of Administration, F835. Findings include: The undated job description for EI #2, the Director of Nursing Service, documented . ACCOUNTABILITY OBJECTIVE Manages the Department of Nursing in accordance with policy and procedure, state and federal regulations to promote high quality care and service to the facility and community . KEY RESPONSIBILITIES . 1. Implements policies/procedures with follow-up and supervision of staff to ensure compliance . Refer to F600, F607, F609, F610, F740, and F838 In a telephone interview with EI #4, a Licensed Practical Nurse (LPN) on 7/24/2018 at 9:40 AM, she referenced a text message sent to her by EI #2, which stated be careful of how you chart so that she (EI #2) didn't have to report incidents as abuse. EI #10 supplied the State survey agency with the text to EI #4 from EI #2, which read Careful how you chart so I don't have to turn it in as abuse . Only chart in general notes no more behavior notes that way we don't draw attention to ourselves. I'll call you in a few and let you know what's going on. In an interview on 7/25/2018 at 9:43 AM, EI #8, a Certified Nursing Assistant (CNA) was asked what was she instructed to do and document when a resident exhibited behaviors. EI #8 stated she was told to not tell the nurse anything because hitting and pushing was not abuse because it was probably not the resident's intention. When asked who gave her those instructions, EI #8 said EI #1, the Administrator; EI #2, the DNS; and EI #15, the Assistant DNS. EI #8 stated these instructions were given during the first of May (2018). During an interview with EI #9, a CNA on 7/25/2018 at 2:59 PM, she stated the staff had a meeting the other day with EI #1, the Administrator and EI #15, the Assistant DNS in which they were told not to use common sense. According to EI #9, the administrator had a piece of paper and he stated if they saw a resident hit or push another resident, that may not be what they really saw; that they would get together and talk about it. (continued on next page)

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Diversicare of Foley	1701 North Alston Street Foley, AL 36535

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with EI #19, a CNA, on 7/27/2018 at 9:40 AM, stated the staff was told that what they saw, as it relates to residents' behaviors/abuse, was not really what they saw. When asked when was she told this, EI #19 stated she told this on Monday by EI #1, the Administrator. In an interview on 7/30/2018 at 10:48 AM, EI #4, a LPN was asked if she considered the incidents that occurred on 4/28/2018 and 5/25/2018 when RI #49 willfully pushed RI #71 down, causing the resident to fall as abuse. EI #4 said yes. When asked if she reported to EI #2 that the incidents were abuse, EI #4 said no. EI #4 explained that the nursing staff was not supposed to tell the administrative staff whether or not it was abuse. They were tell them what happened and they (administrative staff) would make the determination whether or not it was abuse. During an interview with EI #10, a RN on 7/30/2018 at 12:32 PM, she stated she was told by EI #2, the DNS and EI #15, the Assistant Director of Nursing Service (ADNS) that it was not abuse if it was not malicious. EI #10 further stated that now since the State survey agency was in the facility, the facility has said it's abuse whether or not there was an intent to cause harm. In a telephone interview on 7/30/2018 at 4:11 PM, EI #5, a LPN was asked to describe what she observed between RI #49 and RI #85 on 5/2/2018. EI #5 stated RI #85 was attempting to crawl up in a chair and RI #49 slapped RI #85. When asked to describe the slap, EI #5 stated RI #49 held (his/her) arm up, bent the elbow, rotated the arm and slapped RI #85. When asked to define abuse, EI #5 said it was would someone intentionally or willfully intended to cause harm to someone. According to EI #5, she thought this incident was abuse, but after talking with the DNS (EI #2) and EI #3, the Director of Clinical Operations (DCO), they advised her otherwise. EI #5 said they told her it appeared not to be a slap but more of a tap on the face. EI #5 stated she was told she should have used different wording in her charting (documentation). During an interview on 7/30/2018 at 7:51 AM, EI #2, the DNS, stated for the last [AGE] years the facility did not have to report resident on resident altercations involving dementia patients. EI #2 stated she was aware of the regulatory changes that occurred in November (2017), but said the changes had not sunk in with her yet. During a follow-up interview on 7/31/2018 at 1:04 PM, EI #2, the DNS acknowledged she had asked the nursing staff to call her before they documented a resident's fall to ensure the staff was documenting objectively. EI #2 stated there was a lot of subjective documentation. When asked why the staff stated they had to communicate with you before documenting, to ensure the documentation avoided looking as though it was abuse, EI #2 said she didn't know why the staff would say that. EI #2 explained that she was confused about the facility's abuse policy and she didn't know. EI #2 stated she just wanted to the staff to document what they saw and not what they felt. After review of the facility's policy, EI #2 stated she now knows each of the six resident-on-resident altercations should have been considered allegations of abuse. When asked if the allegations of abuse were reviewed by the facility's Quality Assurance committee for the detection of trends/patterns, EI #2 said no. When asked why not, EI #2 said the committee talked about the incidents as falls and not allegations of abuse. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In another interview with EI #2, the DNS on 8/1/2018 at 10:22 AM, she was asked what had staff been told about resident-on-resident abuse. EI #2 replied, she thought the facility missed that. EI #2 stated the facility focused more on exploitation rather than residents with dementia now being considered abuse. EI #2 explained she felt this is where she failed because she didn't not stress that topic. EI #2 stated that part of the policy was not engrained in her thinking until a conference call in May (2018). The job description for EI #1, the Administrator dated July 2018, documented . Accountability Objective Directs, oversees and manages the 24/7 day to day operations of the Diversicare post-acute care center . Key Responsibilities . Serve as the center abuse coordinator. Strives to ensure the safety of all residents within the center; ensures education and understanding of all team members of abuse recognition, protecting and reporting responsibilities; responds swiftly to any allegation of abuse, neglect or misappropriation by protecting, investigating and making any required reporting Ensures compliance with State and Federal Regulations . Leads an effective Quality Assurance and Process Improvement (QAPI) Program . In an interview with the facility's Administrator, EI #1, on 7/31/2018 at 3:53 PM, he was asked about the resident-on-resident altercations that occurred on the facility's Alzheimer's Care Unit (ACU). EI #1 explained that he didn't understand those were allegations of abuse. EI #1 stated before the change in November (2017), there was more latitude to say whether something was intentionally done or not. EI #1 stated they were not in the formal investigative mode when they discovered those situations, so nothing was written down about them. When asked what an investigation into potential abuse should consist of, EI #1 said an investigation consisted of understanding the facts about what happened to accurately determine effective ways to prevent reoccurrences. EI #1 said witnesses should be interviewed, an observation of the area may be needed, and a review of the medical records. When asked why the facility's Abuse Policy was not implemented when these six resident-on-resident altercations occurred, EI #1 said he didn't know. EI #1 was asked why the staff felt as though they were trained that what they saw was not what really what they saw. EI #1 explained he informed the staff to not let their emotions get in the way of their documentation. EI #1 stated some of the documentation (charting) seemed to be exaggerated and the staff had documented objectively not subjectively. EI #1 stated maybe the staffs' assumptions led them to say what they saw was not really what they saw. When asked who would know better what they saw, EI #1 replied, the staff who saw it. ********** On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented Administration Administrator/Abuse Coordinator has reported all of the above mentioned allegations to the state agency and full investigations are ongoing to be completed within 5 days to the state agency. Administrator received in-service education by the Sr. DCO regarding the Facility Abuse policy, Abuse identification and reporting on 8/02/2018. (continued on next page)

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Diversicare of Foley	1701 North Alston Street Foley, AL 36535

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administrator and DNS were placed on administrative leave pending full investigation on 8/02/2018. Interim Administrator in place on 8/03/2018 and Sr Director of Clinical Operations assumed role of interim DNS effective 8/02/2018. The interim administrator started on 08/03/2018. She was trained on abuse policies/regulations by Sr Director of Clinical Operations on 08/03/2018. VP will oversee the full implementation of Abuse policy. ********** After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F835 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00035795. 33414

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 32557 Based on interview and review of the Regional [NAME] President's job description, the facility's governing body failed to provide monitoring and oversight to ensure the facility's abuse policy and procedure was implemented. This deficient practice affected Resident Identifier (RI) #71 and RI #85, two of six sampled residents reviewed for abuse; and placed these residents in immediate jeopardy for serious injury, harm or death. This failure also had the potential to affect the remaining 26 residents who resided on the facility's Alzheimer's Care Unit. On 8/1/2018 at 8:35 PM, the facility's Administrator, Director of Nursing Service, Director of Clinical Operations and Senior Director of Clinical Operations were notified of the findings of immediate jeopardy in the area of Administration, F837. Findings include: DIVERSICARE JOB DESCRIPTION for the Regional [NAME] President, EI #16, dated October 2015, documented . GENERAL PURPOSE Directs and oversees the 24/7 day to day operations of the Diversicare post-acute care centers ESSENTIAL JOB DUTIES . Ensures compliance with State and Federal Regulations . Leads an effective Quality Assurance and Process Improvement (QAPI) Program for the region and ensures all centers have an effective program . Supports, provides guidance and manages the administrators . Refer to F600, F 607, F609, F610, F740, F835, F838 and F867 In an interview on 8/2/2018 at 9:15 AM, EI #16, the [NAME] President of Operations (VPO) was asked who was the facility's governing body. EI #16 replied, the Director of Nursing Service, the Administrator, the Chief Operating Officer and herself. When asked as a member of the governing body, what oversight did she provide to the facility. EI #16 stated she conducted onsite visits of the facility on a quarterly basis. When asked how was the frequency determined, EI #16 stated it depended on the need of the facility. EI #16 was asked if she was aware of the chart audit conducted in July (2018) by the Director of Clinical Operations, EI #3, and the DNS, EI #2. EI #16 replied, no. When asked if she should have been informed of the results of the chart audit, EI #16 said yes. EI #16 explained she should have been aware because it would have been an issue with respect to abuse allegations. EI #16 stated had she been informed of the results of the chart audit, she would have made sure the facility followed the policy and regulations. EI #16 was asked if she had any direct involvement in the facility's Quality Assurance and Performance Improvement committee. EI #16 replied that if she was present in the facility on the day of the meeting, she would attend. In a follow-up interview on 8/2/2018 at 2:34 PM, EI #16, the VPO acknowledged that she was the Administrator's direct supervisor. When asked how she provided oversight to the Administrator, EI #16 said by way of weekly mass calls with all 21 centers for updates. EI #16 stated one-to-one calls were generally done every week and sometimes every other week. When asked what type of things were discussed, EI #16 said some weeks quality issues were discussed, general operations, team member engagement, stewardship and customer satisfaction. When asked if she had knowledge of any of the concerns identified by the State survey agency, EI #16 said no. (continued on next page)

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	015032	A. Building B. Wing	08/04/2018

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

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**********

On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented

Governing Body failed to intervene and direct staff on actions after identifying potential abuse:

VP will act as the governing body presence in the center until compliance has been achieved to ensure that the facility has an active governing body that is responsible for establishing and implementing policies regarding the management of the facility to include the full implementation of the Abuse Policy and Procedures. VP will be overseeing the RVP to ensure implementation of the facility policy and procedure until compliance achieved. Daily phone conferences will be conducted 5 days a week for 4 weeks to apprise the VP of happenings in the center as well as any red events. Schedule has been developed for on-site visits.

The Administrator and DNS have been placed on Administrative leave pending investigation. An interim administrator started on 08/03/2018. Interim Administrator was trained on abuse policies/regulations by Sr Director of Clinical Operations on 08/03/2018. The Sr Director of Clinical Operations assumed the Interim DNS role on 08/03/2018. Both will serve as the Abuse coordinators for the center. Abuse Coordinators Names and Phone numbers are posted throughout the facility for staff reporting. The company has retained the services of an independent consultant on 08/04/2018 to follow up on the effectiveness of the training and provide additional training as needed.

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After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F837 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.

This deficiency was cited as a result of the investigation of complaint/report number AL00035795.

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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 0838 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 32557 Based on interviews and review of the CENTER ASSESSMENT TOOL, the facility failed to address the care and services, as well as staff competencies, necessary to provide care to the residents who reside on the 35-bed secured Alzheimer's Care Unit. This deficient practice affected all 28 residents who reside on the secured Alzheimer's Care Unit and placed these residents in immediate jeopardy for serious injury, harm or death. On 8/1/2018 at 8:35 PM, the facility's Administrator, Director of Nursing Service, Director of Clinical Operations and Senior Director of Clinical Operations were notified of the findings of immediate jeopardy in the area of Administration, F838. Findings include: Diversicare of Foley's CENTER ASSESSMENT TOOL dated 10/31/2017 and reviewed with the QAA/QAPI committee on 11/20/2017, revealed the facility treated residents with diagnoses to include: Alzheimer's Disease and Non-Alzheimer's Dementia. The assessment tool did not indicate the facility had a secure 35-bed Alzheimer's Care Unit. During an interview on 7/31/2018 at 1:04 PM, Employee Identifier (EI) #2, the Director of Nursing Services (DNS) was asked what involvement she had in the facility's assessment. EI #2 said, she, the Administrator, the Assistant DNS and others sat down as a team awhile back to look at the assessment. When asked how the facility's assessment addressed the facility's secured Alzheimer's Care Unit. EI #2 reviewed the assessment and said she didn't see where the facility's assessment addressed the Alzheimer's Care Unit. EI #2 was then asked why it would be important to include the facility's Alzheimer's Care Unit in the facility's assessment. EI #2 said to determine what services the facility provided and staff competencies needed, to ensure the facility was able to provide the best care. In an interview on 7/31/2018 at 3:53 PM, EI #1, the Administrator was asked how the facility's assessment addressed the facility's secured Alzheimer's Care Unit. EI #1 replied, it listed the diagnoses of Alzheimer's and Dementia. When asked if the facility's assessment indicated the facility had a secured Alzheimer's Care Unit, EI #1 said it did not. When asked why not, EI #1 said he felt he covered it in the assessment by listing the diagnoses. EI #1 was asked how the facility's assessment addressed the staff competencies needed to care for the resident's on the Alzheimer's Care Unit. EI #1 said regardless of whether it's written in the assessment, it did not affect whether the facility did dementia training. When asked if the facility's assessment addressed the Alzheimer's Care Unit, EI #1 again stated he felt like it did because it listed diagnoses of Alzheimer's and Dementia. EI #1 was asked who all was involved in the development of the facility's assessment. EI #1 replied, it was a group meeting with the leadership managers. EI #1 explained the list of names on the front page of the assessment were those involved. Diversicare of Foley's CENTER ASSESSMENT TOOL dated 10/31/2017 and reviewed with the QAA/QAPI committee on 11/20/2017, indicated the person involved in completing assessment as: EI #1, the Administrator; EI #2, the DNS; EI #16, the Regional [NAME] President; EI #17, the Medical Director; EI #15, the Assistant DNS; and EI #18, the Social Worker. (continued on next page)

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	015032	A. Building B. Wing	08/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0838 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 8/2/2018 at 9:00 AM, EI #16, the [NAME] President of Operations was asked had she seen the facility's assessment. EI #16 said she worked on it awhile back, before it became regulatory. When asked if the facility's assessment should address the dementia unit (Alzheimer's Care Unit), EI #16 said whether it be by population or mentioning the ACU directly, yes it should encompass the memory care unit (dementia unit). ********** On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented Facility Assessment failed to assure services to provide care to residents residing on the Dementia care unit were addressed: Facility Assessment was revised by the Quality Assurance Committee on 08/02/2018 to include a 35 bed Dementia (Memory Care) unit. Wellness Solutions was added as a service. Impromptu in-servicing, small group discussion, increased oversight by management team (new ACU Programming Manager), collaboration of line staff in program development as well as implementation, more family involvement to individualize programs and plans of care for residents residing on the Dementia unit. After completing investigation into the abuse allegations, the QA committee will schedule another meeting to follow up on the investigative findings as well as the implementation of the corrective action plan addressing the ACU. During this follow up meeting, the QA committee will discuss root cause and make any further revisions to the facility assessment as indicated. ********** After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F838 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00035795.

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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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32557 Based interview and review of the Diversicare of Foley - QAPI CENTER PLAN, the facility's Quality Assessment and Assurance committee failed to review the reported allegations of physical abuse and develop a corrective action plan to prevent recurrence. On 4/28/2018, Resident Identifier (RI) #49 was observed to willfully pushed RI #71 down, causing the resident to fall, cry and scrape the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During the first shift on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed RI #85's face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 on one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, RI #49 forcefully pushed another resident, RI #71 down, causing this resident to fall. Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor. On 5/9/2018, RI #84 was observed by staff to forcefully and intentionally push RI #71 down to the floor, which rendered RI #71 unconscious. Refer to F600 This deficient practice affected RI #71 and RI #85, two of six sampled residents reviewed for abuse; and placed these residents in immediate jeopardy for serious injury, harm or death. These failures also had the potential to affect the remaining 26 residents who reside on the facility's Alzheimer's Care Unit. On 8/1/2018 at 8:35 PM, the facility's Administrator, Director of Nursing Service, Director of Clinical Operations and Senior Director of Clinical Operations were notified of the findings of immediate jeopardy in the area of Quality Assurance and Performance Improvement, F867. Findings include: The Diversicare of Foley - QAPI CENTER PLAN dated 4/17/2018, documented Quality Assurance and Performance Improvement (QAPI) . QAPI Guiding Purpose: QAPI is a data-driven, responsive and proactive process for the purposes of evaluating indicators of the outcomes of care, quality of life and service with a focus on improvement within our center. QAPI involves team members at all levels of the organization and the activities include the following: *Identify opportunities for improvement; *Address gaps in systems or processes; *Develop and implement an improvement or corrective plan; And continuously monitor the effectiveness of our interventions . The facility provided the State Survey Agency with their Quality Assurance and Performance Improvement (QAPI) Meeting for 3/27/2018, 4/17/2018, 5/15/2018, 6/19/2018 and 7/17/2018. A review of these meeting notes indicated the facility did not discuss the repeated incidents of resident/resident abuse that took place on the secure Alzheimer's Care Unit (Dementia unit). (continued on next page)

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	08/04/2018

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 7/31/2018 at 1:04 PM, EI #2, the Director of Nursing Service (DNS) was asked if the allegations of abuse were reviewed by the facility's Quality Assurance committee for the detection of trends/patterns, EI #2 said no. When asked why not, EI #2 said the committee talked about the incidents as falls and not allegations of abuse. ********** On 8/4/2018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which documented QA: Impromptu/Ad-hoc QAPI meeting led by Regional [NAME] Presidents ([NAME], Brooke Sims) and Sr Director of Clinical Operations ([NAME]) held 8/02/2018 with Facility Administrative staff, ACU Programming Manager, Administrator, and Medical Director (via telephone) to discuss findings from survey, completing investigations for concerns, and to review resident to resident altercations occurring on the Dementia unit. Committee to address adverse event monitoring and resident to resident altercations; including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events and resident to resident altercations in the facility, and how the facility will use the data to develop activities to prevent incidents. Plan is to re-convene to identify/ determine root cause of the identified deficient practices. ********** After reviewing the facility's information provided in their AOC and verifying the immediate actions had been implemented, the scope/severity level of F867 was lowered to a E level on 8/4/2018, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as a result of the investigation of complaint/report number AL00035795