Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIE Diversicare of Foley	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing  STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	(X3) DATE SURVEY COMPLETED 08/04/2018 P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	and neglect by anybody.  **NOTE- TERMS IN BRACKETS IN	ed to willfully push RI #71 down, causin later, on 5/2/2018, staff observed RI #9 continued to target RI #85. RI #49 ye door on the resident. After this incidenter, while not being supervised by staff cefully pushed another resident, RI #71 #85 were observed by staff to be push the staff to forcefully and intentionally plants.  RI #71 and RI #85, two of six sampled the jeopardy for serious injury, harm or continued to residents who resided on the facility's y's Administrator, Director of Nursing Staff Clinical Operations were notified of the Neglect, and Exploitation, F600.  Survey Agency received a complaint, in the caller alleged, RI #84 plants was not known by the caller. Then on	ONFIDENTIALITY** 32557  e Survey Agency, the facility's sident Identifier (RI) #71 and RI #85 iside on the secured Alzheimer's  g the resident to fall, cry and scrape 49 slap RI #85. During the first shift belied at RI #85, pushed RI #85's to the staff placed RI #49 on ff, later in the day on 5/25/2018, down causing this resident to fall. ing each other back and forth and push RI #71 down to the floor,  residents reviewed for abuse; and death. This failure also had the Alzheimer's Care Unit.  ervice, Director of Clinical findings of immediate jeopardy in the which the caller reported resident bushed RI #71 and RI #85 down.

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 015032

If continuation sheet Page 1 of 37

STATEMENT OF DEFICIENCIES (IN) PROVIDER SUPPLIER (IN) 15032  STREET ADDRESS, CITY, STATE, ZIP CODE (IN) 1701 North Allston Street Foley, AL 36535  For information on the nursing home's plan to correct this deficiency, please contact the mursing home or the state survey agency.  (X4) ID PREFIX TAC  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  FORD  The facility's Abuse Policy with an effective date of Fabruary 2017, documented. Definitions Abuse means the will full feet in individual must have asded deliberating, not that they must have intent to injury or harm) infliction of injury, unreasonable confinement, intendiation or punishment with resulting physical harm, pain, comenial and public them.  Residents Alfected - Some  1) RI #49 was admitted to the facility on (DATE) with an admitting diagnosis of Dementia with Behavioral Deluturbance.  RI #47's Admission Minimum Data Set (MDS) with an assessment reference date of 4/25/2018, indicated RI was severely impaired in cognitive skills for daily decision making, with long and short term memory problems. According to this MDS, RI #40 diaghayed inattention, delusions, physical behavioral symptoms directed toward others, rejection of care and wandering during this assessment period.  RI #71's Counterly MDS with an assessment reference date of 4/25/2018, indicated RI #71 was admitted to the facility on (DATE) with an admitting diagnosis of Dementia without Behavioral Disturbance.  RI #71's Todarderly 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's Davided physical behavioral symptoms directed toward others during his assessment period.  RI #71's Frogress Notes dated 4/28/2018 at 6.44 PM written by Employee Identifier (EI) #4, a Licensed Practical Nurse (IP) documented. (RI #71) was standing in the memory problems. According to this MDS			1		
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			NO. 0930-0391
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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Disturbance.  RI #85's Admission MDS with an a impaired in cognitive skills for daily to this MDS, RI #85 displayed wan significantly intruded on the privacy.  RI #49 was admitted to the facility to Disturbance.  RI #49's Admission MDS with an a impaired in cognitive skills for daily to this MDS, RI #49 displayed inatt rejection of care and wandering du RI #49's Progress Notes titled Behadocumented Describe Behavior/Mc Resident (RI #85) entered porch and (RI #49) began yelling at resident (RI #49) began yelling at resident (RI #49) head in chair and scientification of the redirect resident that was climbing the lower functioning resident (RI #85) entered porch and the lower functioning resident (RI #85) entered porch and (RI #49) head and RI #85 on 5/2/2 #49 slapped RI #85. When asked the lower functioning resident (RI #85) entered porch and slapped According to EI #5, she thought this Director of Clinical Operations (DC he a slap but more of a tap on the sher charting (documentation). EI #8 DNS.  During an interview on 7/31/2018 at that occurred between RI #49 and during a chart review. EI #2 acknown During an interview on 7/31/2018 at another resident met the definition  3) RI #84 was readmitted to the face Dementia with Behavioral Disturbation Altered Mental Status.  RI #84's Quarterly MDS with an as	con [DATE] with an admitting diagnosis assessment reference date of 4/25/2018 decision making, with long and short the ention, delusions, physical behavioral string this assessment period.  avior Charting dated 5/2/2018 at 11:21 and Resident (RI #49) sitting in chair or the earned began to try and attempt to cling Go away Just go away. The other resides assistant) (EI #6) was in the process of ein chair out of area when the higher fur the earned with the earned RI #85 in the face.  2018 at 4:11 PM, EI #5, a LPN was asked (2018. EI #5 stated RI #85 was attempted at RI #85. EI #5 stated RI #85 was attempted the earned RI #85. EI #5 stated she assessed RI is incident was abuse, but after talking to O), they advised her otherwise. EI #5 stated she was told she she to acknowledged that she did not report at 1:04 PM, EI #2, the DNS stated she will will will have been the action of the earned with the earned will have been the action of the earned will have been the action of the earned with the earned will have been the action of the earned will have been the earned	indicated RI #85 was severely erm memory problems. According sment period and the wandering of Dementia with Behavioral  3, indicated RI #49 was severely erm memory problems. According symptoms directed toward others,  PM, written by EI #5, a LPN, in porch area when lower cognitive into the chair beside (RI #49). ent (RI #85) continued to climb upentering porch area to attempt to inctioning resident (RI #49) slapped and to describe what she observed ting to crawl up in a chair and RI 9 held his/her arm up, bent the il #85 and did not see any redness. with the DNS (EI #2) and EI #3, the said they told her it appeared not to build have used different wording in this incident to the Administrator or was not called about the incident discovered the documentation in handled as an allegation of abuse. Eknowledged a resident slapping inistory to include diagnoses of sed Mood, Anxiety Disorder, and indicated RI #84 was severely

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLII Diversicare of Foley	ER	STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Disturbance.  RI #71's Quarterly MDS with an assimpaired in cognitive skills for daily to this MDS, RI #71 displayed physperiod.  RI #71's Progress Notes dated 5/9/5/92018, RI #71 fell and was momhad a hematoma on left forehead.  In a telephone interview on 7/30/20 When asked what she witnessed, got to RI #71 after the fall, RI #84 vappeared to be that of RI #84, base hand of RI #84 forcefully make conducting an interview on 7/31/2018 at 5/9/2018 incident immediately after thought EI #10 reported it to her. W #71 to fall and hit (his/her) head. W were on the porch and RI #84 pushasked if this action met the definition.  In an interview on 7/31/2018 at 3:5 5/9/2018 between RI #71 and RI #44. A) RI #85 was admitted to the facilia Disturbance.  RI #85's Admission MDS with an assimpaired in cognitive skills for daily to this MDS, RI #85 displayed warms significantly intruded on the privacy.  RI #49 was admitted to the facility of Disturbance.  RI #49's Admission MDS with an assimpaired in cognitive skills for daily be still and the facility of the facility o	on [DATE] with an admitting diagnosis ssessment reference date of 4/25/2018 decision making, with long and short t ention, delusions, physical behavioral	dicated RI #71 was severely erm memory problems. According rard others during this assessment  Registered Nurse (RN), indicate on progress noted indicated RI #71  ked about the 5/9/2018 incident. alf of a forearm. She said when she the hand and arm she saw agernails. EI #10 said she saw the houlder. EI #10 said it was forceful.  ged she became aware of the a became aware, EI #2 stated she she was told RI #84 had caused RI said she was told the residents r1 away from RI #84. EI #2 was  the incident that occurred on  sis of Dementia without Behavioral  indicated RI #85 was severely erm memory problems. According sment period and the wandering  of Dementia with Behavioral  3, indicated RI #49 was severely erm memory problems. According

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		No. 0938-0391
PROVIDER/SUPPLIER/CLIA TIFICATION NUMBER: 32	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
	STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	P CODE
orrect this deficiency, please con	tact the nursing home or the state survey a	agency.
MARY STATEMENT OF DEFIC deficiency must be preceded by	EIENCIES full regulatory or LSC identifying information	on)
19's Progress Notes titled Behamented . Describe Behavior/Modents What was the resident of dent pushed (RI #85's) face intinues to target (RI #85). (RI #85'npt to push, slap, and hit (RI #85') and to push, slap, and hit (RI #85') and between RI #49 and RI #85' standing in the same and punched RI #85' twice in the into the metal door facing. EI #85' med the bathroom door on RI interview on 7/25/2018 at 2:55' 2018 between RI #49 and RI #85' and and punched RI #85' standing in the into the metal door facing. EI #85' and the same and th	avior Charting dated 5/25/2018 1:48 PM lood: Agitation. Restlessness. Aggression of prior to or at the time of behavior/in wall. Staff attempted to separate Rests (S) wanders in an area, (RI #49) will yell 35).  3 AM, EI #8, a CNA was asked to described asks. EI #8 said she was exiting the dinimate doorway of the bathroom across the lee back, then took RI #85 by the back of the said as she and EI #7 were approach #85.  9 PM, EI #9, a CNA was asked to described asks. EI #9 said she saw RI #49 hit RI #41 litercation. EI #9 said this incident occurs shed RI #85's face into the door facing door on RI #85.  18 at 11:28 PM, EI #7, a LPN was ask RI #85. According to EI #7, she was not a yelled at RI #85, pushed RI #85's he she completed a body audit of RI #85. I will because there was a problem. Acc (CNA) who was present to witness the tothe wall and tried to slam a door on finipleted a body audit of RI #85 and re-co. When asked to define abuse, EI #7 is a form and it included hitting, kicking, incident between RI #49 and RI #85 as a form and it included hitting, kicking, incident between RI #49 and RI #85 as a form and it included hitting, kicking, incident between RI #49 and RI #85 as a form and it included hitting, kicking, incident between RI #49 and RI #85 as a form and it included hitting, kicking, incident between RI #49 and RI #85 as a form and it included hitting diagnos was an incident of potential abuse and the potential abuse and seesment reference date of 4/19/18, incidecision making, with long and short to be seesment reference date of 4/19/18, incidecision making, with long and short to be seesment reference date of 4/19/18, incidecision making, with long and short to be seesment reference date of 4/19/18, incidecision making, with long and short to be seesment reference date of 4/19/18, incidecision making, with long and short to be seesment reference date of 4/19/18, incidecision making, with long and short to be seesment reference date of 4/19/18, incident shorts.	A, written by EI #7, a LPN, son noted towards lower cognitive mood: CNA (EI #8) reported this sidents. This Resident (RI #49) at other Resident (RI #85) and with the incident that occurred on the groom with EI #9, another CNA, hall. RI #49 then went up to RI of the head and slammed RI #85's thing the residents, RI #49 with the back twice, and described the incident that occurred on the incident that occurred in RI #49's room, at the pand when RI #85 stumbled into the wall and tried to close she went down the hall in an and the describent or EI #7, she reported to EI to notification, that RI #49 had yelled RI #85. EI #7 stated when EI #2 wriented RI #49. When asked if stated there were several different pushing, slapping and punching. If abusive, EI #7 said yes.  Bed the incident that occurred on the incident involving RI #49 and should have been investigated by the stated RI #71 was severely term memory problems. According the dicated RI #71 was severely term memory problems. According the dicated RI #71 was severely term memory problems. According the dicated RI #71 was severely term memory problems. According the dicated RI #71 was severely term memory problems. According the dicated RI #71 was severely term memory problems. According the resident records and the dicated RI #71 was severely term memory problems. According the resident records and the severely term memory problems. According the resident records and the severely term memory problems. According the resident records and the severely term memory problems.
	EI #8 reported that RI #49 has bor on RI #85. EI #7 said after pt to find either the DNS, EI #1 her to come to the Dementia at she had been told by EI #8 #85, pushed RI #85's head into the Dementia unit, she core was discussed, EI #7 said not of abuse. Physical abuse was a saked if she considered this gan interview on 7/31/2018 at 2018 between RI #49 and RI #2018 between RI #49 and RI #2018 interview on 7/31/2018 at 3:55 that occurred on 5/25/2018 cility as such.  #71 was admitted to the facility bance.  1's Quarterly MDS with an asserted in cognitive skills for daily is MDS, RI #71 displayed physical street in the control of the said in th	#71 was admitted to the facility on [DATE] with an admitting diagnos bance.  1's Quarterly MDS with an assessment reference date of 4/19/18, incred in cognitive skills for daily decision making, with long and short to MDS, RI #71 displayed physical behavioral symptoms directed toward.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Diversicare of Foley		1701 North Alston Street Foley, AL 36535	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0600	RI #49 was admitted to the facility Disturbance.	on [DATE] with an admitting diagnosis	of Dementia with Behavioral
Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	impaired in cognitive skills for daily	ssessment reference date of 4/25/2018 decision making, with long and short to ention, delusions, physical behavioral string this assessment period	erm memory problems. According
	#49) in another Resident's room (n room (number) and this Resident (in doorway. (RI #49) has dementiagoing in other Residents room takin with staff unable to redirect. Resid staff and other Resident's around.  An interview was conducted with E incident that occurred on 5/25/2018 was walking down the hall to take at the hallway but then RI #71 turned RI #49 say, get out of here then sh within three feet of the residents whon one-to-one staff supervision at the state of the state of the residents.	5/2018 at 7:28 PM, written by EI #4, a I umber) and (RI #71) was ambulating de RI #49) started pushing Resident (RI #3 with behavior disturbances - (RI #49) ng their belongings - Hx (history) of aggent alert with confusion - aggravated at and slapping at this nurse making contains and slapping at the surse making contains and the resident their medication. EI #4 around and started to go into a resident e witnessed RI #49 forcefully push RI #4 en the incident occurred. EI #4 further his time, due to an incident that occurred 49 forcefully pushed RI #71 down to the #71 was abuse, EI #4 said yes.	own hallway and started to enter 71) back resulting in (RI #71) falling easily agitated and wanders in unit gressive behavior since admission and angry at this moment - yelling at act multiple times.  EI #4 was asked about the using RI #71 to fall. EI #4 said she said she saw RI #71 at the end of atts room. EI #4 said she then heard 471 down. EI #4 stated she was stated RI #49 was supposed to be ed earlier in the day, but no staff
		Administrator stated in interviews on 7 stated the altercation between RI #49	
	RI #85 was admitted to the facili Disturbance.	ty on [DATE] with an admitting diagnos	is of Dementia without Behavioral
	impaired in cognitive skills for daily	ssessment reference date of 4/6/2018, decision making, with long and short to dering behavior daily during this assess of the activities of others.	erm memory problems. According
	RI #49 was admitted to the facility of Disturbance.	on [DATE] with an admitting diagnosis	of Dementia with Behavioral
	impaired in cognitive skills for daily	ssessment reference date of 4/25/2018 decision making, with long and short to ention, delusions, physical behavioral string this assessment period.	erm memory problems. According
	(continued on next page)		

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 015032

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    Complete   Com		1	1	1
Diversicare of Foley    Total North Alston Street Foley, AL 36535   For information on the nursing home's plan to correct this deficiency, please ontact the nursing home or the state survey agency.		IDENTIFICATION NUMBER:	A. Building	COMPLETED
Diversicare of Foley    T701 North Alston Street Foley, At. 36535   For information on the nursing home's plan to correct this deficiency, please ontact the nursing home or the state survey agency.	NAME OF PROVIDER OR SUPPLIE	 ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)  Residents Affected - Some  Resident	Diversicare of Foley		1701 North Alston Street	
F 0600   Ri #49's Progress Notes dated 6/26/2018 at 2:30 PM, written by El #10, a RN, documented . This resident (RI #49) and another resident (RI #49) with or safety or resident health or safety   During an interview on 7/30/2018 at 12:32 PM, El #10, a RN was asked about the progress note dated 6/26/2018. El #10 stated she was in the office when one of the CNAs came and told her that two residents were on the floor. El #10 stated she went down to the sensory roand observed RI #49 and RI #85 on the floor, with El #11, the Physical Therapist (PT) present. According to El #10, El #11 stated she was working with another resident when RI #49 and 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, El #10 sald on 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, El #11, the PT was asked about the incident occurred between RI #49 and RI #85 on 6/26/2018. El #11 said the incident occurred in the sensory room on the ACU. El #11 said she had taken another resident into the sensory room to complete an evaluation and RI #49 lollowed them into the room and sat down. El #11 said the incident occurred in the sensory room was dever to RI #49 and RI	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(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.  Residents Affected - Some  (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 pushfuldge 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 3:35 PM respectively, stated the altercation between RI #49 and RI #85 that occurred on 6/	(X4) ID PREFIX TAG			on)
(continued on next page)	Level of Harm - Immediate jeopardy to resident health or safety	RI #49's Progress Notes dated 6/2l (RI #49) and another resident (RI # #49) landed in a sitting position. (R During an interview on 7/30/2018 a 6/26/2018. EI #10 stated she was i were on the floor. EI #10 stated she floor, with EI #11, the Physical The with another resident when RI #49 #49's arm. The residents then start this abuse, EI #10 said no based o abuse because pushing, hitting and In an interview on 7/31/2018 at 8:3 RI #49 and RI #85 on 6/26/2018. E said she had taken another resider them into the room and sat down. It then pushed RI #49 in the upper are push/nudge moved RI #49's upper shoved RI #85 the same way. EI #10 before she could get to them both If altercation she witnessed to be abused by the first state of the pushed RI #49 in the upper are push/nudge moved RI #49's upper shoved RI #85 the same way. EI #10 before she could get to them both If altercation she witnessed to be abused at 3:53 PM respectively, 6/26/2018 was abuse.  ***********************************	6/2018 at 2:30 PM, written by EI #10, at 85) were pushing each other and both I #49) did not hit (his/her) head.  It 12:32 PM, EI #10, a RN was asked an the office when one of the CNAs came went down to the sensory room and carapist (PT) present. According to EI #1 came in and sat near her. Then RI #85 ed to push each other and fell to the flon what she had been told by the facility discking was abuse.  1 AM, EI #11, the PT was asked about I #11 said the incident occurred in the state of the sensory room to complete an element in the sensor resident of the sensor resident of the sensor resident to resident altercations element in the sensor resident in the sensor resident in the sensor resident in the senso	a RN, documented . This resident fell . This was witnessed and (RI bout the progress note dated ne and told her that two residents observed RI #49 and RI #85 on the 0, EI #11 stated she was working came and put (his/her) hand on RI for. When asked if she considered to but now she would say it was the incident that occurred between sensory room on the ACU. EI #11 nevaluation and RI #49 followed foom, waked over to RI #49 and and was open, and the force of the each other back and forth, and 11 said she would consider the 17/31/2018 at 1:04 PM and and RI #85 that occurred on  The Compliance (AOC), which free from abuse from other say well as Investigating Abuse. began 8/02/2018 at 1:00PM and 28 staff members trained on as of staff, facility has no agency staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	,	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	<u> </u>	
F 0600  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	RI# 49 and RI# 84 behavior care ple behaviors and to provide interventional tercations similar to those which of 6/26/2018. New interventions are reinterim ACU programming manage psychiatric evaluation to be conducted of 7/28/2018 by attending physician evaluated by Wellness Solutions of Care plans of RIs will be reviewed. Sr Director of Clinical Operations a residing on the Dementia Unit to id perpetrating abuse by 8/03/2018. Under the vised to include interventions to restaff.  All allegations reported to state age Operations and RN reviewed recorpast 30 days to determine if other in abuse identified, Interim Administration procedure. Interviews will conducte any unreported allegations from Matype.  Ongoing programming developed a implemented by the dementia care manager. Start training roster 08/04. The interim administrator started on Director of Clinical Operations on 00 DNS role on 08/03/2018. Both will shames and Phone numbers are positive to monitor and/or revise their corrections.	lans were reviewed/revised by the Sen ons to protect lower cognitive residents occurred on 4/28/2018, 5/02/2018, 5/08 elayed to the direct care staff by direct r, LPN. RIs #84 and 49 will be referred sted on 8/03/2018. Medical evaluation of and on 07/30/2018 by medical director on 08/03/2018. Notes from evaluations after needed changes/ updates after received and RN will review past 30 day document of the diffusion of documented behaviors to identify Jpon identification of documented behaved beginning on 07/29/2018. On 08/03/2018 (Nurses notes, behavioral notes, we needed changes) behavioral notes, we need to review and implement reporting and beginning 8/04/2018 with staff and a day 2018 forward for any resident to resident allored to individual resident prefer staff over all shifts after receiving train 4/2018 on the day shift.  In 08/03/2018. She was trained on abust 18/03/2018. The Sr Director of Clinical Observe as the Abuse coordinators for the	for DCO on 8/02/2018 to address from resident to resident 0/2018, 5/25/2018 X 2, and one on one in-service by the to Wellness Solutions for of RI# 49 was conducted on . RI# 85 and 71 will also be are pending receipt from provider. Seipt of Wellness Solutions notes. Intation of residents currently or risk for being abused and viors care plans will be reviewed, ces with input from the direct care of the reported. Any instances of per facility Abuse policy and lert residents for identification of dent altercations or abuse of any rences to be offered and fing by the Interim ACU programing the policies/regulations by Sr Departations assumed the Interim a center. Abuse Coordinators

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: 015032  NAME OF PROVIDER OR SUPPLIER Diversicare of Foley  STREET ADDRESS, CITY, STATE, ZIP CODE 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.  (XA) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  Develop and implement policies and procedures to prevent abuse, neglect, and theft.  "NOTE-TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 32557 reported allegations of abuse were not reported to the State survey agency, personal designations of abuse when the residents affected - Some  Based on interviews, medical record review and the facility's Abuse Policy, the facility failed to: 1) interview and correct situations to prevent further abuse (Prevention); 2 ensure the Diversing Service (DNS) reported allegations of abuse were not reported to the State survey agency, personal to prevent control to the state survey agency.  Based on interviews, medical record review and the facility's Abuse Policy, the facility failed to: 1) interview and correct situations of prevent further abuse (Prevention); 2 ensure the DNS and Administrator identified situations of resident/resident altercations as abuse (Identification); 4) protect Resident fleethief (R) #17.1 R/#55 and other residents from abuse prepretated parsure the DNS and Administrator identified situations of resident/resident altercations as abuse (Identification); 4) protect Resident fleethief (R) #17.1 R/#55 and other residents for all the protection of the state of the protection of the state of the st				NO. 0936-0391
Diversicare of Foley  1701 North Alston Street Foley, At. 36535  For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.  (XA) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  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, the allegations of abuse to the State survey agency (Reporting); 3) ensure the DNS and Administrator identified situations of resident/resident alteractions as abuse (Identification); 4) protect Resident Identifier (RI) #17, IR #85 and other residents from abuse perpeture) 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 scrap the side of his/her back. Four days later, on 5/2/2018, the first his incident to PRI #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 ushed another resident, RI #71 to be approximated by RI #49 and RI #85 force into a wall and tried to slam a door on the resident. After this incident no, 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 practi		IDENTIFICATION NUMBER:	A. Building	COMPLETED
SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)  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 pering; 3) ensure the DNS and Administrator identified situations of resident/resident altercations as abuse (Identification); 4) protect Resident Identifier (RI) #17.1, RI#85 and other residents from abuse pertrated 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 wilfully push RI#31 down, causing the resident to fall, cry and scrap the side of his/her back. Four days later, on 5/2/2018, staff observed by staff, later in the day on 5/25/2018, the staff noted RI #49 continued to target RI#85. RI #49 selled at RI#9 son mole-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		ER	1701 North Alston Street	P CODE
Each deficiency must be preceded by full regulatory or LSC identifying information	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some  **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 (R) #71, R1 #85 and other residents from abuse perpetrated by R1 #49 and R1 #84 (Protection); and 5) investigate these allegations of physical abuse (Investigation).  On 4/28/2018, R1 #49 was observed to willfully push R1 #71 down, causing the resident to fall, cry and scrap the side of his/her back. Four days later, on 5/2/2018, staff observed R1 #49 span R1 #85. During the first shift on 5/25/2018, the staff noted R1 #49 continued to target R1 #81 #49 span R1 #85. During the first shift on 5/25/2018 is supervision. However, while not being supervised by staff, later in the day on 5/25/2018, during the second shift, R1 #49 forcefully pushed another resident, R1 #71 down, causing this resident to fall. Then on 6/26/2018, R1 #49 and R1 #85 were observed by staff to be pushing each other back and forth and both residents fell to the floor.  On 5/9/2018, R1 #84 was observed by staff to forcefully and intentionally push R1 #71 down to the floor, which rendered R1 #71 unconscious.  These deficient practices affected Resident Identifier (RI) #71 and R1 #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'	(X4) ID PREFIX TAG			ion)
in which abuse, neglect or misappropriation of resident/patient property are more likely to occur .  Refer to F600  (continued on next page)	Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS In Based on interviews, medical record and correct situations to prevent fureported allegations of abuse to the allegations of abuse were not reported allegations of allegations of abuse were not reported allegations of allegations and senior preceded in the senior of abuse of a senior preceded in the senior	Id procedures to prevent abuse, neglected abuse. Adve BEEN EDITED TO PROTECT Control of the review and the facility's Abuse Policy of their abuse (Prevention); 2) ensure the exaministrator, who serves as the Abuse red to the State survey agency (Report of resident/resident altercations as abuse and other residents from abuse perpeters allegations of physical abuse (Invested to willfully push RI #71 down, causin later, on 5/2/2018, staff observed RI #9 continued to target RI #85. RI #49 yed door on the resident. After this incident exert while not being supervised by staff were, while not being supervised by staff to be push abuse to be push a server observed by staff to be push as a server of the remaining 26 residents of the remaining 26 residents of the remaining 26 residents of the later of the later of the remaining 26 residents of the later of	ct, and theft.  ONFIDENTIALITY** 32557  y, the facility failed to: 1) intervene endirector of Nursing Service (DNS) are Coordinator. Furthermore, these enting); 3) ensure the DNS and see (Identification); 4) protect strated by RI #49 and RI #84 tigation).  If the resident to fall, cry and scrape 49 slap RI #85. During the first shift elled at RI #85, pushed RI #85's at the staff placed RI #49 on ff, later in the day on 5/25/2018, down, causing this resident to fall. ing each other back and forth and boush RI #71 down to the floor,  It wo of six sampled residents a serious injury, harm or death, who resided on the facility's ervice, Director of Clinical findings of immediate jeopardy in the serious of resident/patient property fy, intervene and correct situations

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NAME OF PROVIDER OR SUPPLIID	ER	STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	P CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0607  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	An interview was conducted with E discuss the six resident-on-residen EI #2 was asked what actions did t down on 4/28/2018. EI #2 replied, s facility took after the abuse that occ no change in interventions to preve #84 forcefully and intentionally pus replied, an assessment of RI #71 to resident was either difficult to arous what corrective actions the facility to tried to slam a door on the resident to restart RI #49's Depakote medic copyright date of 2017, Depakote is disorders. Depakote can also be us and to prevent migraine headaches further abuse after RI #49 forcefully explained, if she had it to do all ove what she should have known to do asked what actions were taken after residents fell on [DATE], EI #2 replied did not know what was done.  Reporting  The facility's Abuse Policy with a eviolations involving mistreatment, remisappropriation of resident/patien Nursing and to other officials in acc State survey and certification agen within two hours and 2. Any neglec without serious injury within 24 hours.	If #2, the Director of Nursing Service (Dit altercations that occurred on the facility take to prevent further abuse she didn't know what was done. When curred on 5/2/2018 when RI #49 slappe ant another incident. EI #2 was asked whed RI #71 down, rendering RI #71 undo include neurological checks were persecor unconscious and the physician are took after RI #49 yelled at RI #85, push to 05/25/2018, EI #2 said she redirecteration. According to Mosby's 2017 Nurses an anticonvulsant medication used to seed to treat manic episodes related to the seed to	ons), on 7/31/2018 at 1:04 PM to dity's Alzheimer's Care Unit (ACU). Father RI #49 willfully push RI #71 asked what corrective actions the ed RI #85. EI #2 stated there were what actions the facility took after RI conscious on 5/9/2018. EI #2 formed on RI #71 because the ed family were notified. When asked led RI #85's head into a wall and led RI #49 and called the physician ing Drug Reference with a reat various types of seizure objolar disorder (manic depression) ons/steps were taken to prevent to fall on 5/25/2018. EI #2 policy. EI #2 stated she didn't do rective actions were taken. When were pushing each other and both is to make sure they were okay, she ented . Reporting All alleged injuries of unknown source and the Administrator/Director of ished procedures (including to the ssible: 1. Any allegation of abuse ropriation of resident property it be reported by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLII		STREET ADDRESS CITY STATE 71	D CODE
	ER	STREET ADDRESS, CITY, STATE, ZI	PCODE
Diversicare of Foley		1701 North Alston Street Foley, AL 36535	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0607  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	An interview was conducted with E resident-on-resident altercations the when did she become aware that F recall being made aware of this incher within 30 minutes of the occurrentified. El #2 stated she considere reported the allegation of abuse to aware that Rl #49 had slapped Rl at that she discovered this incident du El #2 said no. El #2 explained that aware that Rl #84 forcefully and interview and into a wall and tried to slam a was the incident considered an alle Administrator this allegation of abu aware of the incident that considered abuse, El #2 said yes. Administrator or the State survey a she became aware of the incident to other and fell. El #2 replied, she wif considered this occurrence abuse #2 said no.  Identification  The facility's Abuse Policy with a ewillful (the individual must have act of injury, unreasonable confinemer anguish. Physical abuse includes behavior through corporal punishm QAPI (Quality Assurance Process Refer to F600)  During an interview on 7/30/2018 and have to report resident on resident on resident.	I #2, the DNS, on 7/31/2018 at 1:04 PN at occurred on the facility's Alzheimer's RI #49 willfully pushed RI #71 down on ident. When it was explained to EI #2 tence, EI #2 stated she certainly believe at the occurrence abuse and should hat the Administrator, EI #2 said no. EI #2 #85 on 5/2/2018. EI #2 stated she was uring a chart review. When asked if the she should have reported it but didn't. It is the definition of abuse, EI #2 said yes trator and State survey agency, EI #2 soccurred on 5/25/2018 when RI #49 yes agation of abuse, EI #2 replied, she was gration of abuse, EI #2 said yes. When se, EI #2 said she did not recall. EI #2 on 5/25/2018 when RI #49 forcefully on 5/25/2018 when RI #49 forcefully pre was notified later the night of 5/25/20 EI #2 explained that she did not report gency; EI #2 stated she was out of tow that occurred on 6/26/2018 when RI #4 as pretty sure she was made aware rigger, EI #2 said yes. When asked if the allest the individual of the pretty sure she was made aware rigger, EI #2 said yes. When asked if the allest the individual or punishment with result, intimidation or punishment with result. It is apping, punching and kicking. It is apping to the interest of the interest in November (2017), but said the interest interest in No	If to discuss the six of Care Unit (ACU). EI #2 was asked 4/28/2018. EI #2 stated she didn't hat EI #4, LPN, stated she notified and EI #4, she just didn't recall being over reported it. When asked if she was asked when did she become not notified of this. EI #2 explained allegation of abuse was reported, EI #2 was asked when she became esident to be rendered ed of the incident by the nurse, EI s. When asked if the allegation of said no. EI #2 was asked when she liled at RI #85, pushed RI #85's immediately notified. When asked asked if she reported to the was asked when she became ushed RI #71 down causing the D18. When asked was this incident this allegation of abuse to the n. Lastly, EI #2 was asked when 9 and RI #85 were pushing each this when it happened. When asked egation of abuse was reported, EI ented. Definitions Abuse means the ele intent to injury or harm) infliction thing physical harm, pain or mental It also includes controlling violations shall be reviewed by or trends.
	(continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0607  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	occurred on 4/28/2018 and 5/25/20 as abuse. El #4 said yes. When as El #2 explained that the nursing sta abuse. They were tell them what his whether or not it was abuse.  During an interview with El #10, a land El #15, the Assistant Director of #10 further stated that now since the whether or not there was an intent.  In a telephone interview on 7/30/20 between Rl #49 and Rl #85 on 5/2/ #49 slapped Rl #85. When asked the elbow, rotated the arm and slapped intentionally or willfully intended to was abuse, but after talking with the advised her otherwise. El #5 said the #5 stated she was told she should.  During a follow-up interview on 7/3 nursing staff to call her before they objectively. El #2 stated there was had to communicate with you befor was abuse, El #2 said she didn't kn about the facility's abuse policy and they saw and not what they felt. Aff six resident-on-resident altercationallegations of abuse were reviewed trends/patterns, El #2 said no. Whe falls and not allegations of abuse.  In an interview with the facility's Ad resident-on-resident altercations the that he didn't understand those were (2017), there was more latitude to should be about resident-on-resident abuse. In another interview with El #2, the about resident-on-resident abuse. In another interview with El #2, the about resident-on-resident abuse. In another interview with El #2, the about resident-on-resident abuse. In another interview with El #2, the about resident-on-resident abuse. In another interview with El #2, the about resident-on-resident abuse. In another interview with El #2, the about resident-on-resident abuse. In another on exploitation rathe	2018 at 4:11 PM, EI #5, a LPN was asker /2018. EI #5 stated RI #85 was attempt of describe the slap, EI #5 stated RI #4 dt RI #85. When asked to define abuse, cause harm to someone. According to e DNS (EI #2) and EI #3, the Director of hey told her it appeared not to be a slate have used different wording in her chate 1/2018 at 1:04 PM, EI #2, the DNS actor documented a resident's fall to ensure a lot of subjective documentation. Where documenting, to ensure the documentow why the staff would say that. EI #2 dt she didn't know. EI #2 stated she just the terview of the facility's policy, EI #2 stated why not, EI #2 said the communications who have been considered allegated by the facility's Quality Assurance core asked why not, EI #2 said the communications of abuse. EI #1 stated be say whether something was intentional DNS on 8/1/2018 at 10:22 AM, she was EI #2 replied, she thought the facility mer than residents with dementia now being failed because she didn't stress that to	I down, causing the resident to fall cidents were abuse, El #4 said no. strative staff whether or not it was a would make the determination  and she was told by El #2, the DNS and abuse if it was not malicious. El ity, the facility has said it's abuse and to describe what she observed ting to crawl up in a chair and Rl held his/her arm up, bent the El #5 said it was when someone El #5, she thought this incident of Clinical Operations (DCO), they pout more of a tap on the face. El ring (documentation).  Anowledged she had asked the enth the staff was documenting en asked why the staff stated they anated the staff to document what stated she now knows each of the ions of abuse. When asked if the mmittee for the detection of a littee talked about the incidents as  B PM, he was asked about the scare Unit (ACU). El #1 explained effore the change in November ly done or not.  The sa asked what had staff been told dissed that. El #2 stated the facility ing considered abuse. El #2

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0607  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	circumstances require it, Administra suspected of being the subject of a can be protected. * If the suspected Nursing or designee shall separate circumstances of the alleged incide RI #49 was admitted to the facility of Disturbance.  RI #49's Admission Minimum Data #49 was severely impaired in cogniproblems. According to this MDS, Fidirected toward others, rejection of On 4/28/2018, RI #49 was observe the side of his/her back. Four days on 5/25/2018, the staff noted RI #4 into a wall and tried to slam a door staff supervision. However, while necond shift, RI #49 forcefully push 6/26/2018, RI #49 and RI #85 were residents fell to the floor. Refer to Fide Michael Was observed which rendered RI #71 unconscious. An interview was conducted with E resident-on-resident altercations the what actions did the facility take to down on 4/28/2018. EI #2 replied, simple #85 and other residents after the all there was nothing done. EI #2 was forcefully and intentionally pushed lassessment of RI #71 to include neeither difficult to arouse or unconscincility protected RI #85 and other rand tried to slam a door on the resiphysician to restart RI #49's Depak other residents after RI #49's Depak other known to do asked how the facility protected others.	Set (MDS) with an assessment referentive skills for daily decision making, wit RI #49 displayed inattention, delusions, care and wandering during this assess of the willfully push RI #71 down, causing later, on 5/2/2018, staff observed RI #49 continued to target RI #85. RI #49 ye on the resident. After this incident the stot being supervised by staff, later in the led another resident, RI #71, down, causing supervised by staff, later in the led another resident, RI #71, down, causing supervised by staff, later in the led another resident, RI #71, down, causing supervised by staff, later in the led another resident, RI #71, down, causing supervised by staff to be pushing each follow.  If #2, the DNS, on 7/31/2018 at 1:04 PN at occurred on the facility's Alzheimer's protect RI #71 and other residents after she didn't know what was done. When louse that occurred on 5/2/2018 when F asked how the facility protected RI #72 and the physician and family were residents after RI #49 yelled at RI #85, dent on 5/25/2018, EI #2 said she redii ote medication. EI #2 was asked how the gadin, she would follow the facility's protect RI #71 down causing RI #72 and took full responsibility for it; no conter residents after it was observed RI #ATE, EI #2 replied other than looking a	all remove a resident/patient where the resident/patient's safety it, the Administrator/Director of the access to each other until the of Dementia with Behavioral and short term memory physical behavioral symptoms is ment period.  If the resident to fall, cry and scrape 49 slap RI #85. During the first shift alled at RI #85, pushed RI #85 face staff placed RI #49 on one-to-one and additional to fall. Then on other back and forth and both for the discussion of the size of the first shift alled at RI #71 down to the floor,  If to discuss the six and forth and both for the first shift alled at RI #85, pushed RI #71 asked what was done to protect RI RI #49 willfully pushed RI #71 asked what was done to protect RI RI #49 slapped RI #85. EI #2 stated I and other residents after RI #84 cious on 5/9/2018. EI #2 replied, an RI #71 because the resident was an otified. When asked how the pushed RI #85's head into a wall rected RI #49 and called the he facility protected RI #71 and I to fall on 5/25/2018. EI #2 policy. EI #2 stated she didn't do rective actions were taken. When 49 and RI #85 were pushing each

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(X4) ID PREFIX TAG	AG SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0607	Investigation		
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 Any is an allegation of abuse, the center must report the alleged violation to the Administrator/Director Nursing, the Chief Compliance Officer, and other officials, and also initiate an immediate investigat prevent further potential abuse. Based on the investigation findings, the center will implement correct or to be prevent recurrence. All investigations shall be conducted by the Administrator/Director or subject matter expert unless there is a conflict of interest or they are implicated in the alleged violation occurs when none of these people are available, the manager in che responsible for initiating the investigation procedure unless there is a conflict of interest or the persimplicated in the alleged violations. The investigation shall include interviews of team members, viexident/patients, volunteers and vendors who may have knowledge of the alleged incident. Factu information only should be documented, not assumptions, speculation or conclusions. Written stat from involved parties should not be requested as all information will be documented on the investigation as the kept in a secure administ The medical record should be reviewed to determine resident/patient's past history and condition relevance to the alleged violation. Federal law requires the center to have evidence of investigation elevance to the alleged violations. The investigation form or state required form shall be completed after the investigation form the center shall make reasonable efforts to determine the cause of the alleged violation an corrective action consistent with the investigation findings and to eliminate any ongoing dangers to resident/patient or other resident/patients to attend the resident/patient's condition and more be taken to prevent recurrence, where appropriates Appropriate steps shall be taken to prevent recurrence, where appropriates appropriate. Appropriate of the steps shall be taken to prevent recurrence, where app		the Administrator/Director of an immediate investigation and enter will implement corrective. Administrator/Director of Nursing plicated in the alleged violations. In able, the manager in charge is lict of interest or the person is wis of team members, visitors, a alleged incident. Factual conclusions. Written statements comented on the investigation form ept in a secure administrative file and the state of federal law. Corrective for the alleged violation and its evidence of investigations of completed after the investigation is state or federal law. Corrective for the alleged violation and take any ongoing dangers to the corror of Nursing in conjunction with the tient's condition and measures to libe taken to prevent recurrence of the The steps taken should be essof this form shall be kept in the arry for continuity of care for the equired by state law, shall be the six resident-on-resident hen asked in there was an enen RI #49 and RI #71, EI #2 said hat occurred on 5/2/2018 between the the six resident-on-resident hen asked in there was an investigation done of the the allegation of abuse that the allegation of abuse that asked if there was an investigation and RI #71, EI #2 no. When asked the just didn't do what she was was an investigation into the life investigation and life investigation into the life investigation into the life investigation and life investigation and life investigation into the life investigation and life investigation and life investigation into the life investigation and life investigation a

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0607  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	During an interview on 7/31/2018 a investigative mode when they disca asked what an investigation into pounderstanding the facts about what reoccurrences. El #1 said witnesse a review of the medical records. Wispecified in the facility's Abuse Political of the medical records. Wispecified in the facility's Abuse Political Education review abuse training by 8/02/2018.  All center staff provided group in-sea Abuse Policy to include definitions and/or catastrophic reactions of resprotection and prevention of subseabuse policy to include identification interpretive guidelines for resident all staff have received training. One Additional trainings scheduled for 8 agency staff. No staff member will In-service education regarding Aburesident to resident abuse of any ty Operations on 8/02/2018 at 8:00AN with Dementia. Interim Administration 08/03/2018.  All of the above referenced allegatic Coordinator as of 8/02/2018.  All investigations shall be conducted allegations with the complete investing the required 5 days of the report.  The Administrator and DNS have be administrator started on 08/03/2018. The Sr	at 3:35 PM, EI #1, the Administrator sta overed these situations, so nothing was otential abuse should consist of, EI #1 s t happened to accurately determine eff es should be interviewed, an observation hen asked why these allegations of about	ted they were not in the formal is written down about them. When said an investigation consisted of ective ways to prevent on of the area may be needed, and use were not investigated, as  If Compliance (AOC), which  The initial Operations regarding Facility erventions to deal with aggressive conitoring to ensure resident and when. Implementation of the restigating Abuse. Inclusion of the last 1:00PM and will continue until trained on as of 8/03/2018. The initial entities and training after 8/04/2018. The interpretive Guidelines for DNS by the Sr Director of Clinical ent altercations involving residents rector of Clinical Operations on gency by the Administrator/Abuse  of Nursing. The above referenced end to the state survey agency within ending investigation. The interim egulations by Sr Director of Clinical did the DNS role on 08/03/2018.

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER: 015032  A. Building B. Wing  STREET ADDRESS, CITY, STATE, ZIP CODE 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 0607  Level of Harm - Immediate jeopardy to resident health or safety  After reviewing the facility's information provided in their AOC and verifying the immediate actions had beer implemented, the scope/severity level of F607 was lowered to a E level on 8/4/2018, to allow the facility tim to monitor and/or revise their corrective actions as necessary to achieve substantial compliance.				NO. 0930-0391
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 0607  Level of Harm - Immediate jeopardy to resident health or safety  After reviewing the facility's information provided in their AOC and verifying the immediate actions had beer 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.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED
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)  ***********************************	NAME OF PROVIDER OR SUPPLIER  Diversicare of Foley		1701 North Alston Street	IP CODE
(Each deficiency must be preceded by full regulatory or LSC identifying information)  ***********************************	For information on the nursing home's	plan to correct this deficiency, please con		agency.
Level of Harm - Immediate jeopardy to resident health or safety  After reviewing the facility's information provided in their AOC and verifying the immediate actions had beer 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.	(X4) ID PREFIX TAG			ion)
jeopardy to resident health or safety 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.	F 0607	*******		
g	Level of Harm - Immediate jeopardy to resident health or safety	implemented, the scope/severity le	vel of F607 was lowered to a E level o	n 8/4/2018, to allow the facility time
33413	Residents Affected - Some	This deficiency was cited as a resu	alt of the investigation of complaint/repo	ort number AL00035795.
		33413		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018	
NAME OF DROVIDED OD SUDDIU		STREET ADDRESS CITY STATE 71	D CODE	
NAME OF PROVIDER OR SUPPLIE	EK	STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street	PCODE	
Diversicare of Foley		Foley, AL 36535		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0609	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.			
Level of Harm - Immediate jeopardy to resident health or safety	32557			
Residents Affected - Some	Based on interviews and review of the facility's Abuse Policy, the Director of Nursing Service (DNS) failureport allegations of physical abuse to the Administrator, who serves as the Abuse Coordinator. Further 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 the side of his/her back. Four days later, on 5/2/2018, staff observed RI #49 slap RI #85. During th on 5/25/2018, the staff noted RI #49 continued to target RI #85. RI #49 yelled at RI #85, pushed R face into a wall and tried to slam a door on the resident. After this incident the staff placed RI #49 one-to-one staff supervision. However, while not being supervised by staff, later in the day on 5/25 during the second shift, RI #49 forcefully pushed another resident, RI #71 down, causing this resid Then on 6/26/2018, RI #49 and RI #85 were observed by staff to be pushing each other back 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.			
		y's Administrator, Director of Nursing Se Clinical Operations were notified of the 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)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLII		STREET ADDRESS CITY STATE 71	D CODE
	ER	STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street	PCODE
Diversicare of Foley		Foley, AL 36535	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0609  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	An interview was conducted with E resident-on-resident altercations the when did she become aware that F recall being made aware of this incher within 30 minutes of the occurrentified. El #2 stated she considere reported the allegation of abuse to aware that Rl #49 had slapped Rl at that she discovered this incident due El #2 said no. El #2 explained that aware that Rl #84 forcefully and interpreted to the Administration of subuse was reported to the Administration awall and tried to slam a was the incident considered an alle Administrator this allegation of abuse aware of the incident that courred resident to fall. El #2 replied that strength considered abuse, El #2 said yes. Administrator or the State survey a she became aware of the incident other and fell. El #2 replied, she wife considered this occurrence abuse #2 said no.  ***********************************	I #2, the DNS, on 7/31/2018 at 1:04 PN at occurred on the facility's Alzheimer's RI #49 willfully pushed RI #71 down on ident. When it was explained to EI #2 thence, EI #2 stated she certainly believe at the occurrence abuse and should hat the Administrator, EI #2 said no. EI #2 #85 on 5/2/2018. EI #2 stated she was uring a chart review. When asked if the she should have reported it but didn't. It is the definition of abuse, EI #2 said yes trator and State survey agency, EI #2 soccurred on 5/25/2018 when RI #49 yes adoor on RI #85. EI #2 replied, she was gation of abuse, EI #2 said yes. When se, EI #2 said she did not recall. EI #2 on 5/25/2018 when RI #49 forcefully on 5/25/2018 when RI #49 forcefully explained that she did not report gency; EI #2 stated she was out of tow that occurred on 6/26/2018 when RI #4 as pretty sure she was made aware rig ency; EI #2 said yes. When asked if the allest a pretty sure she was made aware rig ency; EI #2 said yes. When asked if the allest a pretty sure she was made aware rig ency; EI #2 said yes. When asked if the allest a pretty sure she was made aware rig ency; EI #2 said yes. When asked if the allest a pretty sure she was made aware rig ency; EI #2 said yes. When asked if the allest a pretty sure she was made aware rig ency; EI #2 said yes. When asked if the allest a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency is a pretty sure she was made aware rig ency i	If to discuss the six of Care Unit (ACU). EI #2 was asked 4/28/2018. EI #2 stated she didn't hat EI #4, LPN, stated she notified and EI #4, she just didn't recall being over reported it. When asked if she was asked when did she become not notified of this. EI #2 explained allegation of abuse was reported, EI #2 was asked when she became esident to be rendered ed of the incident by the nurse, EI s. When asked if the allegation of said no. EI #2 was asked when she liled at RI #85, pushed RI #85's immediately notified. When asked asked if she reported to the was asked when she became ushed RI #71 down causing the D18. When asked what this incident this allegation of abuse to the n. Lastly, EI #2 was asked when 9 and RI #85 were pushing each this when it happened. When asked egation of abuse was reported, EI incidence (AOC), which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER (SUPPLIER DISORDER)  NAME OF PROVIDER OR SUPPLIER  Diversicare of Foley  STREET ADDRESS, CITY, STATE, ZIP CODE 1701 North Alston Street Foley, AL. 38635  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)  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, very perfect of the state of the	enters for Medicare & Medic	said Services	No. 0938-0391		
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)  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 assumed the DNS ro 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 on 8/02/2018 at 8:00AM.  After reviewing the facility's information provided in their AOC and verifying the immediate actions had bee implemented, the scope/severity level of F609 was lowered to a E level on 8/4/2018, to allow the facility tir 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.		IDENTIFICATION NUMBER:	A. Building	COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  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 was summed the DNS ro 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 bee implemented, the scope/severity level of F609 was lowered to a E level on 8/4/2018, to allow the facility tint 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.		ER	1701 North Alston Street	P CODE	
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Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some  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 assumed the DNS ro 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 bee implemented, the scope/severity level of F609 was lowered to a E level on 8/4/2018, to allow the facility tire 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.	(X4) ID PREFIX TAG			ion)	
	Level of Harm - Immediate jeopardy to resident health or safety	All identified allegations reported to Clinical Operations and Director of weekly notes, daily notes) over the been reported. Any instances of ab per facility policy and procedure.  The interim administrator started or Director of Clinical Operations on 0 on 08/03/2018. Both will serve as the Phone numbers are posted through oversight and monitoring of the report and monitoring of the repor	e state agency beginning on 7/29/2018. Nursing Services reviewed records (Ni past 30 days to determine if other incidence identified, Interim Administrator with 08/03/2018. She was trained on abus 18/03/2018. The Sr Director of Clinical Control of the Abuse coordinators for the center. Anout the facility. Sr Director of Clinical Corting process.  The ce education by the Sr Director of Clinical Corting process.  The ce education by the Sr Director of Clinical Corting process.  The ce education by the Sr Director of Clinical Corting provided in their AOC and verifying vel of F609 was lowered to a E level of Ctive actions as necessary to achieve services.	On 08/04/2018, Sr Director of urses notes, behavioral notes, dents occurred that should have ill follow and implement reporting se policies/regulations by Sr Operations assumed the DNS role Abuse Coordinators Names and Operations will provide clinical ical Operations on 8/02/2018 at in 8/4/2018, to allow the facility time substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X3) DATE SURVEY COMPLETED OBGO42018  NAME OF PROVIDER OR SUPPLIER Diversioner of Folley  STREET ADDRESS, CITY, STATE, ZIP CODE 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)  Respond appropriately to all alloged violations.  32557  Based on interviews and review of the facility's Abuse Policy, the facility failed to investigate allegations of abuse perpetiated by Resident Identifier (Ri) #49 and RI #84, two cognitively impaired residents who reside the side of his/fire back. Flour days later, on 35/2018, staff observed RI #48 siap RI #85. Dural MRI #85 on S15/2019, the staff noted RI #40 continued to large RI #86. RI #49 year later in the day on 5/25/2019, the staff noted RI #40 continued to large RI #86. RI #49 year later in the day on 5/25/2019, the staff noted RI #40 continued to large RI #86. RI #49 year later in the day on 5/25/2019, the staff noted RI #40 continued to large RI #86. RI #49 year later in the day on 5/25/2019, during the second #RI #87 in Continued to large RI #86. RI #49 year later in the day on 5/25/2019, during the second #RI #87 in Continued on nursi-on-one staff supervision. However, while not being supervised by staff in the public residents in the factor.  On 5/36/2018, RI #84 was observed by staff to forcefully and intentionally public RI #71 down counts; the resident to fall. The nursidents for the horr.  On 5/36/2018, RI #84 was observed by staff to forcefully and intentionally public RI #71 down counts. The state as to had the potential to affect the remaining 2 feeds on the facility A schlinest State During Staff in the remaining 2 feeds when we considered for RI manufactor, Director of Nursing Service, Director of Idinaria.  On 8/1/2018 at 8.35 PM, the facility A dem				
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.  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  F 0610  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 5/25/2018, 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 yellade 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 forefully pushed another resident #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 Oper		IDENTIFICATION NUMBER:	A. Building	COMPLETED
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.  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  F 0610  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 5/25/2018, 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 yellade 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 forefully pushed another resident #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 Oper	NAME OF DROVIDED OR SURDIU	FD.	CTREET ADDRESS CITY STATE 7	ID CODE
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.  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  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 Alcheimer'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 #45 pushed 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 ystaff, 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		EK		P CODE
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  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 (R) #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 yelled at RI #85, pushed RI #85's face into a wall and tried to slam a door on the resident. Affected H #90 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's were observed by staff to be pushing each other back and forth and both residents fell to the floor.  On 5/9/2018, RI #49 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			Foley, AL 36535	
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Investigation		Operations and Senior Director of 0	Clinical Operations were notified of the	
		Findings include:		
(continued on next page)		Investigation		
		(continued on next page)		

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

			110. 0730-0371
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLIE	:R	STREET ADDRESS, CITY, STATE, ZI	P CODE
Diversicare of Foley		1701 North Alston Street Foley, AL 36535	
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	X TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0610  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	is an allegation of abuse, . the center. Nursing, the Chief Compliance Office prevent further potential abuse. Base actions to prevent recurrence. All into or subject matter expert unless there the event an alleged violation occur responsible for initiating the investig implicated in the alleged violations. resident/patients, volunteers and veinformation only should be docume from involved parties should not be or a state required form. The documenter minimal that the resident patients in the investigation complete and provided to survey as action The center shall make reason corrective action consistent with the resident/patient or other resident/patient or other resident/patient or other resident/patient or other recurrence, where the incident. This may include in-seducumented. Documentation all allegenter. Documentation in the medic resident/patient. Separate incident maintained and produced in accord.  Refer to F600  In an interview with EI #2, the DNS altercations that occurred on the fact investigation into the allegation of a no. When asked if there was an investigation into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred on 5/25/2018 between RI into the allegation of abuse that occurred between RI into the allegation of abus	fective date of February 2017, docume er must report the alleged violation to to cer, and other officials, and also initiate sed on the investigation findings, the convestigations shall be conducted by the re is a conflict of interest or they are improved in the second of the secon	he Administrator/Director of an immediate investigation and enter will implement corrective. Administrator/Director of Nursing plicated in the alleged violations. In able, the manager in charge is lict of interest or the person is was of team members, visitors, a alleged incident. Factual conclusions. Written statements cumented on the investigation form tept in a secure administrative file. It is thistory and condition and its evidence of investigations of completed after the investigation is a state or federal law. Corrective if the alleged violation and take any ongoing dangers to the tor of Nursing in conjunction with tient's condition and measures to all be taken to prevent recurrence of the. The steps taken should be ites of this form shall be kept in the ary for continuity of care for the equired by state law, shall be  the six resident-on-resident hen asked in there was an een RI #49 and RI #71, EI #2 said that occurred on 5/2/2018 between if there was an investigation done of RI #84. EI #2 replied, she did not not the allegation of abuse that asked if there was an investigation and RI #71, EI #2 no. When asked is the just didn't do what she was was an investigation into the 8. EI #2 answered no and

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 015032

If continuation sheet Page 21 of 37

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLIE	- n	STREET ADDRESS CITY STATE 71	D CODE
	ER .	STREET ADDRESS, CITY, STATE, ZI	PCODE
Diversicare of Foley		1701 North Alston Street Foley, AL 36535	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 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, El #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, El #1 said an investigation consisted of understanding the facts about what happened to accurately determine effective ways to prevent reoccurrences. El #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, El #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 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.		
	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 implemented, the scope/severity level of F610 was lowered to a E level on 8/4/2 to monitor and/or revise their corrective actions as necessary to achieve substant			8/4/2018, to allow the facility time
	This deficiency was cited as a resu	It of the investigation of complaint/repo	rt number AL00035795.
	(continued on next page)		

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLII Diversicare of Foley	ER	STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0610	33413		
Level of Harm - Immediate jeopardy to resident health or safety			
Residents Affected - Some			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDED OR CURRU		CERTAIN ARREST CITY CTATE 71	D CODE
NAME OF PROVIDER OR SUPPLII	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Diversicare of Foley		1701 North Alston Street Foley, AL 36535	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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	Ensure each resident must receive services.	and the facility must provide necessar	y behavioral health care and
Level of Harm - Immediate jeopardy to resident health or safety.	**NOTE- TERMS IN BRACKETS F	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 32557
Residents Affected - Some	and address the behavioral health resident/resident abuse. On 4/28/2 resident to fall, cry and scrape the slap RI #85. During the first shift or yelled at RI #85, pushed RI #85's fithe staff placed RI #49 on one-to-of the day on 5/25/2018, during the scausing this resident to fall. Then of each other back and forth and both.  The facility further failed to ensure respond to behaviors and track and effective in meeting the needs of the staff responsible for behavior mana Director, was not aware of any systematice affected RI #49, one of 11 immediate jeopardy for serious injuresidents identified by the facility at On 8/2/2018 at 5:08 PM, the facility at Findings include:  RI #49 was admitted to the facility in Disturbance. RI #49 has a medical and Agitation.  RI #49's Admission Minimum Data #49 was severely impaired in cogn problems. According to this MDS, If	y's Regional [NAME] President was not	epeated incidents of bush RI #71 down, causing the in 5/2/2018, staff observed RI #49 tinued to target RI #85. RI #49 on the resident. After this incident of being supervised by staff, later in nother resident, RI #71 down, observed by staff to be pushing 0 that directed the staff on how to t's behavioral care plan was calating behaviors; however, the the Unit Manager/Memory Care RI #49's behaviors. This deficient fors, and placed this resident in the had the potential to affect all 20 diffied of the findings of immediate of Dementia with Behavioral cified Psychosis and Restlessness ance date of 4/25/2018, indicated RI th long and short term memory physical behavioral symptoms

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
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		STREET ADDRESS, CITY, STATE, ZI	PCODE
Diversicare of Foley		1701 North Alston Street Foley, AL 36535	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0740  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	RI #49's care plan titled Sometimes staff and others, confrontational be some of the lower cognitive resider Episodes of (my mimicking lower cothers, . will not interfere with the sinterventions listed were: During epslowly and speaking to me in a calr of discussion. Encourage me to pasituations and people that trigger in my doctor if my behaviors interfere to help soothe me.  On 4/28/2018, RI #49 was observe the side of his/her back. Four days on 5/25/2018, the staff noted RI #4 face into a wall and tried to slam a one-to-one staff supervision. Howe during the second shift, RI #49 and RI both residents fell to the floor. Refer RI #49's behavior charting for the tithreatening behavior; on 4/28/2018, 5/18/2018, 5/20/2018, 5/18/2018, 5/20/2018, 5/19/2018 and 5/20/2018, 5/20/2018, 5/19/2018 and 5/20/2018, 6/9/2018, 6/92/2018, 6/22/2018, 6/24/2018 and 6/26/2014 abusive language on 6/8/2018, 6/9 pinching/scratching/spitting on 6/22/RI #49's behavior charting for the tithreatening on 7/5/2018 and 6/26/2014 abusive language on 6/8/2018, 6/9/2018, 6/9/2018, 6/9/2018, 6/9/2018, 7/11/2018, 7/1	is I show behavior symptoms/risks Becchavior and (of) lower cognitive resident ints initiated on 4/27/2018 and last revision or some period 6/1/2018 and pushing staff and afety or well-being of myself or others to bisodes of inappropriate behaviors, plear and steady voice - trying to redirect in an and steady voice - trying to redirect in riticipate in activities to give me someth propropriate behaviors. Help me maintain with my functioning and give meds as a did to willfully push RI #71 down, causing later, on 5/2/2018, staff observed RI #9 continued to target RI #85. RI #49 yed door on the resident. After this incident ver, while not being supervised by staff refully pushed another resident, RI #71 #85 were observed by staff to be pushing at the period 4/1/2018 to 4/30/2018, indicated RI #49 was pushing; and on 4/30/2018 and 5/25/2018. RI #49 was land 5/25/2018. RI #49 had three instances abusive language on 5/5/2018, indicated for the period 6/1/2018 to 6/30/2018, indicate	oming confused/cursing/pushing at as . I also mimic the behavior of ed on 6/22/2018, had a goal of ad others), pushing, pulling on thru my next review. The ase re-direct me by approaching ne to an alternative activity or topic ing to focus on. Help me avoid ain a consistent daily routine. Notify ordered. Offer me a quieter setting go the resident to fall, cry and scrape 49 slap RI #85. During the first shift liled at RI #85, pushed RI #85's the staff placed RI #49 on f, later in the day on 5/25/2018, down, causing this resident to fall. Ing each other back and forth and ated on 4/21/2018, RI #49 had abusive language.  ated RI #49 displayed threatening 25/2018. RI #49 displayed pushing kicking/hitting on 5/5/2018, es of grabbing, on 5/5/2018, ated RI #49 displayed threatening 2018 and 6/27/2018. RI #49 was g on 6/8/2018, 6/19/2018, g on 6/24/2018. RI #49 used instance of  ated RI #49 had one instance of 18. RI #49 was kicking/hitting on /2018.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
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Diversicare of Foley		STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	PCODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0740  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	was behavior management address facility was utilizing. When asked if EI #12 said no. EI #12 was asked wimplement prevention techniques. If RI #49 displayed on admission. EI #12 acknowledged RI #49's behavior. RI #49 forcefully pushed another redone. When asked what was done said the residents were separated a best. EI #12 explained that she had reviewed the behavior charting, it wit trends, who was working with the reassaulted RI #85 on 5/25/2018, EI the resident's care plan was revised that interfere with functioning, give asked about RI #49's behaviors for #12 then said the incidents involving been decreased if RI #49's behaviors.  On 8/4/2018 at 3:06 PM, the facility documented  Behavior Management: Facility failed and trend behaviors.  Facility RN reviewed and updated the plans will be reviewed and updated sor Director of Clinical Operations reduced behaviors, general approaches for environment. Post behavioral explanations of the behavior exhibited.  Sr Director of Clinical Operations por 7:00AM on Dementia Care Guideling minimize distressing behavioral explanations and provide a safe environt cause or trigger of the behavior level behaviors and provide a safe environt cause or trigger of the behavioral explanations.	5 AM, EI #12, the Unit Manager/Memorsed on the ACU. EI #12 stated there were the facility had a policy/procedure or provided system she utilized to track reside EI #12 replied, there was not a system. #12 replied, RI #49 was exit seeking, so recare plan was initiated on 4/27/2018 esident down on 4/28/2018, EI #12 said after RI #49 was observed to slap anotical and redirected. EI #12 commented I fail do never reviewed RI #49's behavior chard vould have allowed her to see the inform #12 said she was not sure as she was don 6/22/2018 with an intervention to medications as ordered and take reside the month of June, EI #12 said RI #49 and the month of June, EI #12 said RI #49 and the month of June, EI #12 said RI #49 and the month of June, EI #12 said RI #49 and the behavior care plan for RI #49 on 08 and been tracked.  If you would have possibly been averaged in the month of June, EI #12 said RI #49 and the behavior care plan for RI #49 on 08 and been tracked.  If you would have possibly been averaged in the behavior care plan for RI #49 on 08 and the behavior care	as not a truly focused program the rotocol for behavior management, nt behaviors in an attempt to EI #12 was asked, what behaviors o a wanderguard was placed. EI & When asked what was done after I she didn't see anything that was ther resident on 5/2/2018, EI #12 led that situation, I really did my arting. EI #12 said if she would have mation with the day and time, he after RI #49 yelled and physically on vacation. EI #12 commented, notify the physician of behaviors ent to a quieter setting. When 's behaviors were escalating. EI bided and behaviors could have when the set is a first or a did and behaviors could have be a first of the provided by dents occur. Training to utilize thance calm environment and the managing of challenging haviors and provide a safe use and is designed to understand the interventions.  If members beginning 8/3/2018 at to enhance calm environment and se with dementia to understand the ecorrect intervention. Sr Director of eduled additional trainings on

			NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLIER  Diversicare of Foley		STREET ADDRESS, CITY, STATE, Z 1701 North Alston Street Foley, AL 36535	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact 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)		ion)
F 0740  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Services, Director of Clinical Educathe daily clinical meeting for reside exhibited behaviors which contributed address results of possible root carclinical team to assure compliance.  Impromptu in-servicing, small groute Programming Manager), collaborated family involvement to individualize  ***********************************	nterim Director of Nursing Services, Astion, Unit Managers, will complete the nts with documented behaviors to dete ted to the incident occurrence. Clinical use beginning 8/4/2018. Interim Admin.  p discussion, increased oversight by mitton of line staff in program developmenter programs and plans of care for resider ation provided in their AOC and verifying the lottive actions as necessary to achieve staff of the investigation of complaint/reposition of the investigation of complaint/reposition.	post behavioral event tool during ermine possible root cause of team will then update care plan to istrator will attend meetings with the management team (new ACU not as well as implementation, more nots residing on the Dementia unit.  In the immediate actions had been note 8/4/2018, to allow the facility time substantial compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF DROVIDED OR SURDIJED		STREET ADDRESS CITY STATE 71	D CODE
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street	PCODE
Diversicare of Foley		Foley, AL 36535	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0835	Administer the facility in a manner	that enables it to use its resources effec	ctively and efficiently.
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS F	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 32557
safety		job description's, the facility administra	
Residents Affected - Some	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, I	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 # didn't have to report incidents as abuse. EI #10 supplied the State survey agency with the text to EI #4 froi EI #2, which read Careful how you chart so I don't have to turn it in as abuse. Only chart in general notes 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 a 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 day with EI #1, the Administrator and EI #15, the Assistant DNS in which they were told not to use com sense. According to EI #9, the administrator had a piece of paper and he stated if they saw a resident hush another resident, that may not be what they really saw; that they would get together and talk about		
	(continued on next page)		

			No. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLIER  Diversicare of Foley		STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	P CODE
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.	
(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	saw, as it relates to residents' behat told this, EI #19 stated she told this  In an interview on 7/30/2018 at 10: occurred on 4/28/2018 and 5/25/20 as abuse. EI #4 said yes. When as EI #4 explained that the nursing states abuse. They were tell them what his whether or not it was abuse.  During an interview with EI #10, a I and EI #15, the Assistant Director of #10 further stated that now since the whether or not there was an intent.  In a telephone interview on 7/30/20 between RI #49 and RI #85 on 5/2; #49 slapped RI #85. When asked the elbow, rotated the arm and slapped intentionally or willfully intended to was abuse, but after talking with the advised her otherwise. EI #5 said the #5 stated she was told she should.  During an interview on 7/30/2018 and have to report resident on resident on the regulatory changes that occurrent of the regula	CNA, on 7/27/2018 at 9:40 AM, stated aviors/abuse, was not really what they so on Monday by El #1, the Administrator 48 AM, El #4, a LPN was asked if she 218 when RI #49 willfully pushed RI #7: ked if she reported to El #2 that the including appended and they (administrative staff).  RN on 7/30/2018 at 12:32 PM, she stated for Nursing Service (ADNS) that it was reported to cause harm.  218 at 4:11 PM, El #5, a LPN was asked at 4:11 PM, El #2, the DNS, stated for the policy of the facility is policy. El #1, and the facility is policy, El #2, the DNS acked by the facility is Quality Assurance and the facility is Quality Assurance and the facility is Quality Assurance and asked why not, El #2 said the common asked	considered the incidents that 1 down, causing the resident to fall cidents were abuse, EI #4 said no. strative staff whether or not it was 1 would make the determination would make the determination and the describe what she observed the facility, the facility has said it's abuse and to describe what she observed the facility has said it's abuse and to describe what she observed the facility has would someone EI #5 said it was would someone EI #5, she thought this incident of Clinical Operations (DCO), they put more of a tap on the face. EI ring (documentation).  The last [AGE] years the facility did the facts. EI #2 stated she was aware changes had not sunk in with her anowledged she had asked the the staff was documenting an asked why the staff stated they intation avoided looking as though it explained that she was confused awanted to the staff to document asked if a committee for the detection of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLIER  Diversicare of Foley		STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG		MARY STATEMENT OF DEFICIENCIES  n deficiency must be preceded by full regulatory or LSC identifying information)	
Evel of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	about resident-on-resident abuse. I focused more on exploitation rathe explained she felt this is where she the policy was not engrained in her.  The job description for EI #1, the A Directs, oversees and manages the Key Responsibilities. Serve as the within the center; ensures educatio and reporting responsibilities; responsibilities	DNS on 8/1/2018 at 10:22 AM, she was EI #2 replied, she thought the facility may retain the residents with dementia now being failed because she didn't not stress the thinking until a conference call in May diministrator dated July 2018, documents as 24/7 day to day operations of the Divincenter abuse coordinator. Strives to even and understanding of all team memberonds swiftly to any allegation of abuse, gray required reporting Ensures computed ity Assurance and Process Improve ministrator, EI #1, on 7/31/2018 at 3:53 at occurred on the facility's Alzheimer's re allegations of abuse. EI #1 stated be say whether something was intentional mode when they discovered those situated an investigation into potential abuse anding the facts about what happened the #1 said witnesses should be interviewed dical records. When asked why the facent-on-resident altercations occurred, Expert were trained that what they saw was fif to not let their emotions get in the work (charting) seemed to be exaggerated a stated maybe the staffs' assumptions leaved who would know better what they say as the staff of the above mentioned as reported all of the above mentioned as reported within 5 days to the state and or regarding the Facility Abuse policy, Assumptions the staff of the above mentioned as reported within 5 days to the state and or regarding the Facility Abuse policy, Assumptions the staff of the above mentioned as reported within 5 days to the state and or regarding the Facility Abuse policy, Assumptions the staff of the above mentioned as reported within 5 days to the state and or regarding the Facility Abuse policy, Assumptions the staff of the above mentioned as reported within 5 days to the state and or regarding the Facility Abuse policy, Assumptions the staff of the above mentioned as reported within 5 days to the state and or regarding the Facility Abuse policy, Assumptions the staff of the above mentioned as the complete of the above mentioned as the complete of the above mentioned as the complete of the above mention	dissed that. EI #2 stated the facility ing considered abuse. EI #2 hat topic. EI #2 stated that part of (2018).  Inted . Accountability Objective ersicare post-acute care center . Insure the safety of all residents hers of abuse recognition, protecting ineglect or misappropriation by obliance with State and Federal ment (QAPI) Program .  By PM, he was asked about the socare Unit (ACU). EI #1 explained effore the change in November ly done or not. EI #1 stated they uations, so nothing was written should consist of, EI #1 said an or accurately determine effective ed, an observation of the area may cility's Abuse Policy was not EI #1 was as not what really what they saw. By of their documentation. EI #1 and the staff had documented dother to say what they saw was saw, EI #1 replied, the staff who

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLI	NAME OF PROVIDER OR SURPLIED		IP CODE
Diversicare of Foley  Diversicare of Foley  STREET ADDRESS, CITY, STATE, ZIP CODE  1701 North Alston Street Foley, AL 36535		PCODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0835  Level of Harm - Immediate jeopardy to resident health or safety	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.		
Residents Affected - Some	********		
	After reviewing the facility's information provided in their AOC and verifying the immediate actions had be implemented, the scope/severity level of F835 was lowered to a E level on 8/4/2018, to allow the facility 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		
	33414		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Diversicare of Foley		1701 North Alston Street Foley, AL 36535	PCODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0837  Level of Harm - Immediate jeopardy to resident health or safety	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		
Residents Affected - Some	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 was the facility's governing body. EI #16 replied, the Director of Nursing Service, the Administrator, the 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 asked if she was aware of the chart audit conducted in July (2018) by the Director of Clinical Operations #3, and the DNS, EI #2. EI #16 replied, no. When asked if she should have been informed of the results the chart audit, EI #16 said yes. EI #16 explained she should have been aware because it would have the an issue with respect to abuse allegations. EI #16 stated had she been informed of the results of the chaudit, she would have made sure the facility followed the policy and regulations. EI #16 was asked if she any direct involvement in the facility's Quality Assurance and Performance Improvement committee. EI 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 s by way of weekly mass calls with all 21 centers for updates. EI #16 stated one-to-one calls were general done every week and sometimes every other week. When asked what type of things were discussed, El 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 identifiby the State survey agency, EI #16 said no.  (continued on next page)		

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Facility ID: 015032

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NAME OF PROVIDED OR CURRUER		CTDEET ADDRESS SITV STATE 7	D CODE	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	PCODE	
Diversicare of Foley	Diversicare of Foley 1701 North Alston Street Foley, AL 36535			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)	
F 0837	********			
Level of Harm - Immediate jeopardy to resident health or safety	On 8/4/2018 at 3:06 PM, the facility documented	v submitted an acceptable Allegation of	f Compliance (AOC), which	
Residents Affected - Some	Governing Body failed to intervene	and direct staff on actions after identify	ying 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 visit.  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.			
	********			
	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 resu	It of the investigation of complaint/repo	ort number AL00035795.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018
NAME OF PROVIDER OR SUPPLIER  Diversicare of Foley		STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street Foley, AL 36535	P CODE
For information on the nursing home's	plan to correct this deficiency please con	tact the nursing home or the state survey	agency
(X4) ID PREFIX TAG	TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		<u>-</u>
F 0838  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Conduct and document a facility-wiresidents competently during both of 32557  Based on interviews and review of and services, as well as staff comp 35-bed secured Alzheimer's Care Unit and death.  On 8/1/2018 at 8:35 PM, the facility Operations and Senior Director of the area of Administration, F838.  Findings include:  Diversicare of Foley's CENTER AS committee on 11/20/2017, revealed Disease and Non-Alzheimer's Dem 35-bed Alzheimer's Care Unit.  During an interview on 7/31/2018 at (DNS) was asked what involvementhe Assistant DNS and others sated the facility's assessment addressed assessment and said she didn't see #2 was then asked why it would be assessment. El #2 said to determinensure the facility was able to provide and Dementia. When asked if the funit, El #1 said it did not. When ast the diagnoses. El #1 was asked ho care for the resident's on the Alzhein diagnoses of Alzheimer's and Dem facility's assessment. El #1 replied, the list of names on the front page.	the CENTER ASSESSMENT TOOL, the tetencies, necessary to provide care to Unit. This deficient practice affected all placed these residents in immediate jet is a comparable. The facility treated residents with diagnentia. The assessment tool did not indicated. The facility treated residents with diagnentia. The assessment tool did not indicated the facility's assessment. It is the facility's secured Alzheimer's Care where the facility's assessment addressed in the facility's assessment addressed to the design of the what services the facility provided and the heat to the facility's assessment addressed in the facility did dementia training. When the facility did dementia training we have the facility did dementia training. When the facility did dementia training we have a group meeting with the leader of the assessment were those involved the person involved in completing assessed the Regional [NAME] President; El	purces are necessary to care for s.  The facility failed to address the care the residents who reside on the 28 residents who reside on the 28 residents who reside on the expandy for serious injury, harm or dervice, Director of Clinical findings of immediate jeopardy in and reviewed with the QAA/QAPI noses to include: Alzheimer's icate the facility had a secure  The Director of Nursing Services are the Alzheimer's Care Unit. EI #2 reviewed the essed the Alzheimer's Care Unit. EI eimer's Care Unit in the facility's and staff competencies needed, to the diagnoses of Alzheimer's Care unit in the assessment by listing the staff competencies needed to a of whether it's written in the nen asked if the facility's elt like it did because it listed volved in the development of the riship managers. EI #1 explained dispessment as: EI #1, the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018	
NAME OF PROVIDER OF SUPPLIED		CIDEET ADDRESS CITY CTATE 7	ID CODE	
NAME OF PROVIDER OR SUPPLIER  Diversicare of Foley  1701 North Alston Street Foley, AL 36535		PCODE		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)	
F 0838  Level of Harm - Immediate jeopardy to resident health or safety	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).			
Residents Affected - Some	********			
	On 8/4/2018 at 3:06 PM, the facility documented	submitted an acceptable Allegation or	f Compliance (AOC), which	
	Facility Assessment failed to assur were addressed:	e services to provide care to residents	residing on the Dementia care unit	
	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.			
	******			
	implemented, the scope/severity le to monitor and/or revise their correct	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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015032	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018	
NAME OF DROVIDED OD SUDDIU	NAME OF PROVIDED OF CURRULE		D CODE	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI 1701 North Alston Street	PCODE	
Diversicare of Foley		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.			agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0867	Set up an ongoing quality assessm corrective plans of action.	nent and assurance group to review qua	ality deficiencies and develop	
Level of Harm - Immediate jeopardy to resident health or safety	**NOTE- TERMS IN BRACKETS F	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 32557	
Residents Affected - Some	I .	Diversicare of Foley - QAPI CENTER F ittee failed to review the reported allegate 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 which rendered RI #71 unconsciou	l by staff to forcefully and intentionally ρ s. Refer to F600	oush RI #71 down to the floor,	
	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)			

F 0867  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some  On 8/4/2018 at 3:0 documented  QA:  Impromptu/Ad-hoo Director of Clinical Manager, Adminis investigations for a Committee to addr by which the facilit information relating will use the data to cause of the identi				
For information on the nursing home's plan to correct this deficiency must be supported by the correct this deficiency must be supporte		(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 08/04/2018	
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On 8/4/2018 at 3:0 documented  QA:  Impromptu/Ad-hoo Director of Clinical Manager, Adminis investigations for a Committee to address by which the facility information relating will use the data to cause of the identification.  ***********************************	use were reviewed El #2 said no. Whe gations of abuse.	PM, EI #2, the Director of Nursing S by the facility's Quality Assurance co n asked why not, EI #2 said the comr	mmittee for the detection of	
Impromptu/Ad-hoo Director of Clinical Manager, Adminis investigations for of Committee to address by which the facilit information relating will use the data to cause of the identi	018 at 3:06 PM, the facility submitted an acceptable Allegation of Compliance (AOC), which ted			
implemented, the stomonitor and/or r	al Operations ([NA istrator, and Medic concerns, and to dress adverse evelity will systematicate to develop activitied deficient pra	d by Regional [NAME] Presidents ([NME]) held 8/02/2018 with Facility Adnal Director (via telephone) to discuss eview resident to resident altercation at monitoring and resident to resident lly identify, report, track, investigate, ts and resident to resident altercations to prevent incidents. Plan is to re-catices.	ninistrative staff, ACU Programming findings from survey, completing s occurring on the Dementia unit. altercations; including the methods analyze and use data and in the facility, and how the facility	
	e scope/severity le revise their correc	tion provided in their AOC and verifying the control of F867 was lowered to a Elevel of tive actions as necessary to achieve the total of the investigation of complaint/rep	on 8/4/2018, to allow the facility time substantial compliance.	