

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2023
NAME OF PROVIDER OR SUPPLIER Diversicare of Riverchase		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Riverhaven Drive Birmingham, AL 35244	
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)		
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility document titled POSITION DESCRIPTION for Social Services Supervisor the facility failed to ensure the care planning process facilitated the inclusion of resident and resident's representative for Resident Identifier (RI) #3 and RI #10 when the facility did not schedule a care plan meeting with resident or resident's representative.</p> <p>This affected two of three residents sampled for the right to participate in care planning.</p> <p>Findings Include:</p> <p>A review of facility document titled POSITION DESCRIPTION for Social Services Supervisor which was signed by Employee Identifier (EI) #13 on 11/03/2022 revealed .KEY RESPONSIBILITIES . 3. Documents progress and updates plans of care at the interdisciplinary care conference .</p> <p>RI #3 was admitted on [DATE] with diagnoses that included End Stage Renal Disease. RI #3 was discharged on 12/20/2022.</p> <p>On 04/26/2023 at 10:45 AM an interview was conducted with RI #3's responsible party and care conference person. He/she reported the facility did not communicate anything with them regarding a care plan meeting and he/she did not attend a care plan meeting.</p> <p>RI #10 was admitted on [DATE] with diagnoses that included Infection Following a Procedure, Other Surgical Site, Subsequent Encounter. RI #10 was discharged on 04/25/2023.</p> <p>On 04/26/2023 at 2:45 PM an interview was conducted with RI #10's family and care conference person. He/she reported the facility did not communicate anything with them regarding a care plan meeting and he/she did not attend a care plan meeting.</p> <p>On 04/26/2023 at 5:00 PM an interview was conducted with EI #11, Licensed Practical Nurse, Minimum Data Set (MDS) and Care Plan Assistant. EI #11 said that through interviews with residents and care plan meetings, she incorporated the residents and resident representative's goals and preferences into resident's care plans. EI #11 said social services should schedule care plan meetings with residents and sponsors upon admission and quarterly. EI #11 said it was important to include the resident and sponsor in care plan meetings to ensure the residents needs were met and the care plan was individualized. EI #11 continued, the care plan meeting was to address any specific concerns or request.</p> <p>(continued on next page)</p>		

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: 015145
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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/27/2023 at 10:40 AM an interview was conducted with EI #4, Director of Care Coordination who said social services was responsible for scheduling care plan meetings and inviting resident and resident's representative.</p> <p>On 04/27/2023 at 10:50 AM an interview was conducted with EI #13, Social Services Director. EI #13 said social services, himself, was responsible for scheduling care plan meetings with residents and resident's representative. EI #13 said he scheduled the care plan meeting whenever it was determined to be necessary for residents or family. EI #13 said the care plan meeting should be within seven days of admission and then quarterly but were not being done at that frequency. EI #13 said he did not know when a care plan meeting was held for RI #3 or his/her representative. EI #13 said there was not an actual care plan meeting with RI #10 or his/her representative. EI #13 said when a care plan meeting was held it was documented on a sign-in sheet if held in-person and entered into resident notes in the electronic health record when representatives participated via phone.</p> <p>On 04/27/2023 at 12:15 PM an interview was conducted with EI #2, Registered Nurse, Director of Nursing. EI #2 said the EI #11, EI #13, or EI #4 was responsible for scheduling care plan meeting with residents and resident's representatives. EI #2 said nurse representative, therapy representative, social services, and other disciplines based on resident's needs or request should attend the meeting with resident and resident's representative. EI #2 said it was important to include the resident and representative in care plan meetings to update them on the care, changes, and communicate expectations and goals.</p> <p>*****</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00042883.</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, and review of a policy titled, Abuse, Neglect, Misappropriation, Exploitation Policy, the facility failed to protect Resident Identifier (RI) # 5, from misappropriation of resident property when his/her bag with personal belongings were placed in an unlocked closet when he/she was out of the facility. RI # 5 transferred to the hospital on [DATE] and on 12/27/2022 when his/her Power of Attorney came to retrieve his/her belongings the bag was missing from the unlocked closet.</p> <p>This affected RI #5, one of three residents sampled for abuse concerns.</p> <p>Findings Include:</p> <p>A review of the abuse policy titled, Abuse, Neglect, Misappropriation, Exploitation Policy, dated January 2019, revealed, .Purpose: To prohibit and prevent .misappropriation of resident property .</p> <p>RI # 5 was admitted to the facility on [DATE] and discharged to the hospital on [DATE].</p> <p>On 12/28/2022 at 6:44 PM, the State Survey Agency received an initial report from the facility regarding an allegation of possible Misappropriation of Resident Property involving RI # 5. According to this initial report, RI # 5 was sent to the hospital on [DATE]. RI # 5's phone, phone charger and watch were locked up for safe keeping. On 12/23/2022 the remaining personal items were placed into a linen closet for storage. On 12/27/2022 RI # 5's Power of Attorney came to get his/her personal items and stated a wallet was missing.</p> <p>An interview was conducted with Employee Identifier (EI) # 4, Director of Care Coordinator on 4/26/2023 at 11:30AM. EI #4 stated that on 12/23/2022 she was instructed to removed RI # 5's personal items from his/her room due to a new admission. EI # 4 stated she placed clothing items and ball cap in a black carry-on suitcase. She said she looked in the black bag before placing the items and did not see a wallet, credit cards or state issued identification. She said she put the bag with the items in the west wing linen closet. She reported the linen closet was not locked and employees had access to the room. She further stated on 12/27/2022 an employee went to retrieve the bag and it was not in the linen closet. The clothes and ball cap were on a shelf in the linen closet. EI # 4 said several employees looked for the bag, but it was never located. She said she had no idea what happened to the bag. She further stated if asked now to remove personal items from a resident's room she would place them in a locked secure area.</p> <p>An interview was conducted with EI #2, Director of Nursing (DON) on 4/26/2023 at 12:00PM. EI # 2 recalled the incident involving RI # 5's missing items. She said in December of 2022 RI # 5 was discharged to the hospital. She said she became aware of the missing suitcase on 12/27/2022 when the sponsor came to retrieve RI #5's items. EI #2 stated during the time that RI #5 was gone, EI #4 had placed some of RI #5's items, including the black bag in the [NAME] wing linen closet. When RI #5's sponsor came to collect the items staff went to get items but the black bag was not there. EI # 2 said at that time the sponsor said a wallet, identification and credit cards were in the bag and were missing. EI # 2 said RI # 5's bag with personal items were placed in an unlocked closet on 12/23/2022 and if it had been locked it would have been harder for the suitcase to go missing due to limited people having access to a locked closet.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/26/2023 at 4:45PM, an interview was conducted with EI # 1, Administrator. EI # 1 stated he was not employed at the facility in December but had reviewed the report concerning RI #5. He stated the bag and wallet went missing and was never found. When asked what could have been done to prevent the bag from being misplaced, he said it could have been put in a secure area with a lock. He further said residents' personal items should be kept in a secure location until they are retrieved to ensure they are not misplaced.</p> <p>*****</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00042818.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the Centers for Medicare & (and) Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, the facility failed to ensure Resident Identifier (RI) #15's Quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 03/22/2023 was accurately coded to reflect RI #15 used continuous oxygen during this assessment period.</p> <p>This deficient practice affected RI #15, one of 17 sampled residents for whom MDS assessments were reviewed.</p> <p>Findings include:</p> <p>RI #15 was admitted to the facility on [DATE], and has diagnoses to include Shortness of Breath (SOB).</p> <p>A review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1, dated October 2019, revealed:</p> <p>. Section O0100: Special Treatments, Procedures, and Programs .</p> <p>O0100C, Oxygen therapy</p> <p>Code continuous or intermittent oxygen via (by way of) mask, cannula, etc., delivered to a resident to relieve hypoxia in this item.</p> <p>A review of RI #15's Order Summary Report (Physicians Orders) revealed RI #15 had a Physicians Order, with an order date of 02/28/2023, for Oxygen at 2 liters/minute via NC (nasal cannula) to maintain saturations greater than 90% (percent) every shift for SOB.</p> <p>RI #15's Quarterly MDS assessment, with an ARD of 03/22/2023, did not code RI #15 as using oxygen during this assessment period.</p> <p>A review of RI #15's March 2023 e-MAR (electronic-Medication Administration Record) revealed RI #15 had received oxygen at 2 liters/minutes from 03/01/2023 through 03/31/2023.</p> <p>On 04/28/2023 at 4:23 PM, the surveyor conducted an interview with Employee Identifier (EI) #11, the MDS Assistant. When asked should RI #15 be coded on his/her most recent MDS assessment dated [DATE] for oxygen use, EI #11 said if RI #15 used the oxygen between 03/16/2023 - 03/22/2023 he/she should be coded for oxygen use. The surveyor asked EI #11 where it would be found if RI #15 had used oxygen during those time frames. EI #11 said on the eMAR or in the nurse's notes. EI #11 said looking at RI #15's e-MAR the oxygen was used during those time frames and should have been coded on the 03/22/2023 MDS assessment. The surveyor asked EI #11 was the 03/22/2023 MDS assessment accurate. EI #11 said no. EI #11 said the importance of a resident having an accurate MDS assessment was to ensure the plan of care would be correct.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure Resident Identifier (RI) #3's comprehensive care plan was developed timely.</p> <p>This affected RI #3; one of three residents sampled for timely development of comprehensive care plans.</p> <p>Findings Include:</p> <p>RI #3 was admitted on [DATE] with diagnosis that included End Stage Renal Disease. RI #3 was discharged on 12/20/2022.</p> <p>A review of RI #3's chart revealed only a base line care plan was in place for RI #3 and comprehensive care plans were never developed.</p> <p>On 04/26/2023 at 5:00 PM an interview was conducted with Employee Identifier (EI) # 11, Minimum Data Set (MDS) and Care Plan Assistant. EI #11 said all residents should have a Comprehensive Care Plan developed by day 21 of each resident's stay. EI #11 said RI #3 did not have a Comprehensive Care Plan developed or implemented. EI #3 said RI #3's care plan should have been developed by 12/05/2022. EI #11 said it was important for residents to have a Comprehensive Care Plan because if the care plan was not created, the [NAME] could not be created, and direct staff would not have instructions on how to best care for the resident.</p> <p>On 04/27/23 at 12:15 PM an interview was conducted with EI #2, Registered Nurse, Director of Nursing. EI #2 said RI #3 did not have a Comprehensive Care Plan developed. EI #2 said the Comprehensive Care Plans are developed based on resident's assessment and informed staff on how to provide care to each resident.</p> <p>*****</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00042883.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2) A review of [NAME] and Perry's FUNDAMENTALS OF NURSING with a copyright date of 2017, Chapter 32 Medication Administration, page 657, revealed the following</p> <p>STEP . I. Do not leave medications unattended . RATIONALE . Nurse is responsible for safekeeping of drugs.</p> <p>Review of a facility policy titled, Medication Administration General Guidelines, with a reviewed/updated date of 04/2022, revealed the following:</p> <p>POLICY:</p> <p>Medications are administered . in accordance with good nursing principles and practices .</p> <p>RI #2 was admitted to the facility on [DATE] and has a diagnosis of Cognitive Communication Deficit.</p> <p>RI #2's April 2023 Order Review Report (Physician's Orders) revealed RI #2 was receiving Gabapentin 300MG two capsules (600MG) at bedtime and Norco 7.5-325MG every 4 (four) hours as needed for pain.</p> <p>On 04/27/2023 at 9:41 AM, the surveyor observed RI #2 take an amber-colored bottle without a label out of his/her nightstand drawer. The bottle had a plastic medicine cup in the opening at the top of the bottle. The surveyor observed six medications in the bottom of the bottle. When asked what they were and how he/she got the medication, RI #2 stated that five of the pills were Norco and one of them was Gabapentin and that most of the nurses just left them on his/her overbed table with a cup of water and then left the room. RI #2 said that Norco caused constipation, so he/she did not take it unless he/she was in a lot of pain, but some of the nurses brought it to him/her whether it had been requested or not, so he/she would take out the Norco and put it in the bottle to take when he/she really needed it. When asked which nurse left the medications, RI #2 said that he/she did not recall any specific nurse and stated that several of them left his/her medications. The surveyor explained that staff would have to be notified that the medication was in the room and RI #2 said that the Administrator could come, and he/she would tell him about the medications, and it was explained that a management nurse would also have to be in the room to get the medication and RI #2 agreed. The surveyor stepped to the door and asked a staff member to ask the Administrator to come to RI #2's room and also asked her to get a nurse manager.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/27/2023 at 9:57 AM, Employee Identifier (EI) #1, the Administrator, entered RI #2's room, along with EI #3, Registered Nurse (RN)/Assistant Director of Nursing (ADON). When asked, RI #2 explained to them that nurses had left his/her medications on the overbed table and that they brought the Norco whether he/she had asked for it or not and it caused constipation, so he/she would take it out of the medicine cup and put it in the bottle and then take it when he/she really needed it later. RI #2 said he/she did not know why the Gabapentin was in there because he/she usually took it when the nurses left it. The surveyor asked EI #3 to get RI #2's medication cards to verify the medications in the bottle matched what was in the cards in the medication cart. EI #3 left the room and returned with RI #2's medication card of Norco 7.5MG and Gabapentin 300MG. She donned gloves and took a white caplet out of the bottle on RI #2's overbed table and held it beside the card of Norco 7.5MG with imprint M366 and compared it to white pills in bottle and stated that they matched the Norco 7.5 in the card. EI #3 then picked the yellow capsule out of the bottle and compared it to the card of Gabapentin with imprint of IP102 and stated that it matched the Gabapentin in the card. EI #3 was asked to describe the appearance of the pills and she said that they were intact, and she could read the imprint on them. When asked if she could determine if the pills had been administered to RI #2, she said it did not look like it to her because they were dry and intact and admitted that it was consistent with what RI #2 was reporting about the pills being left in the medication cup on the overbed table.</p> <p>On 04/27/2023 at 10:24 AM, an interview was conducted with EI #1, Administrator. EI #1 said that he was notified by a staff member that a state surveyor had requested for him and a registered nurse to come to RI #2's room. When asked, EI #1 said that he observed what appeared to be a prescription bottle container with a total of six medications and what appeared to be a medication cup with a hole in the top covering the prescription bottle. He said that RI #2 indicated that five of them were Norco and one was Gabapentin and that he/she was being given PRN (as needed) medication without him/her asking for them and that they would be left in the medication cup on his/her table and that he/she knew what those medications were for and they were constipating so he/she chose to hold on to the medication in the drawer and take them at a later time when he/she felt that the medication was needed. EI #1 further stated that the nurses should ensure that when they give medications that they stay with the residents to see the residents swallow the medications, but since RI #2's medications were intact he would have to say that they did not do that with him/her.</p> <p>On 04/28/2023 at 7:33 AM, an interview was conducted with EI #15, Licensed Practical Nurse (LPN). She stated that the only medications that should be left at a resident's bedside was if they had an order for an inhaler or something like that that could be kept at bedside. When asked how RI #2 would have been able to put his/her Norco 7.5 MG and Gabapentin 300 MG in a bottle in his/her nightstand, EI #15 said someone would have had to leave the medication in his/her room for that to happen, but she did not recall leaving either of those medications in RI #2's room.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/28/2023 at 8:47 AM, an interview was conducted with EI #3, RN/ADON. When asked how PRN narcotics should be administered, EI #3 said she did not give out a PRN unless the resident asked for it and she made sure that they took it while she was in there. She stated she became aware that there were narcotic medications in RI #2's room because EI #1, Administrator, had told her that State needed a nurse in his/her room, and she saw it when she entered the room. She further stated that she observed one Gabapentin 300 MG and five Norco 7.5-325 MG pills and that they were intact and did not appear to have been in RI #2's mouth. She said RI #2 told them that the nurses brought the Norco in and would just set them on the table and leave them even though he/she had not asked for it so he/she would take them out and put them in a bottle and would take them later when he/she needed them. When asked what the concern was with narcotics being left in RI #2's room, EI #8 said he/she could overdose or somebody else could go in there and take them so either way nothing good was going to come from it.</p> <p>On 04/28/2023 at 5:03 PM, an interview was conducted with EI #2, RN/Director of Nursing (DON). EI #2 was asked how should nurses administer PRN narcotics and she said if a resident requests a PRN, the nurse should assess them, validate the order, punch it out of the blister pack, sign it out on the narcotic book, take it in and then go back to the cart and document it on the MAR so that they can follow up and document the effectiveness of it. When asked what was determined about why RI #2 had five Norco and one Gabapentin in a bottle in his/her room that were still intact, EI #2 stated some of the nurses might have left them in there like RI #2 said, but they should have stayed with him/her until they were taken.</p> <p>3) Review of a facility policy titled, Oxygen Guideline, with an effective date of 01/01/2022, documented:</p> <p>POLICY</p> <p>Medical oxygen is classified by the Food and Drug Administration as a drug and therefore it is provided in accordance with a health care provider's order and in accordance with acceptable standards of practice.</p> <p>RI #14 was readmitted to the facility on [DATE].</p> <p>RI #14's April 2023 Order Summary Report (Physician's Orders) revealed RI #14 had an order for Oxygen Use: 3L (liters)/MIN (minute) via (by way of) nasal cannula continuously every day and every night.</p> <p>Review of RI #14's April 2023 Weights and Vitals Summary documented that RI #14 was on Room Air from 04/01/2023 - 04/17/2023, and from 04/19/2023 - 04/26/2023.</p> <p>On 04/26/2023 at 2:48 PM, the surveyor observed that there was no oxygen infusing and there was no concentrator in RI #14's room. The surveyor noted that RI #14 did not appear to be in any distress and he/she was able to talk and answer questions with no obvious signs or symptoms of shortness of breath. When asked, RI #14 said that he/she was on oxygen when he/she readmitted to the facility at the end of last month, but he/she had not used the oxygen, but a few days and he/she did not recall when the last time there was any oxygen in his/her room.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/27/2023 at 7:43 AM, the surveyor observed that there was no oxygen infusing and there was no concentrator in RI #14's room.</p> <p>On 04/28/2023 at 8:47 AM, an interview was conducted with EI #3, RN/ADON. When asked EI #3 said that she remembered seeing RI #14 with a cannula in his/her nose when he/she came back from the hospital after hip surgery, but she did not recall seeing it since then. She said she was not aware that RI #14 had an order for continuous oxygen but agreed that the order was not being followed since he/she did not have an oxygen concentrator in his/her room.</p> <p>On 04/28/2023 at 11:41 AM, an interview was conducted with EI #5, Licensed Practical Nurse (LPN). EI #5 said she was not aware that RI #14 had an order for continuous oxygen and had not seen an oxygen concentrator in his/her room. She stated that all doctor's orders should be followed and the concern with not following them would be that the resident was not getting what the doctor wanted them to have and RI #14 could have become short of breath if he/she needed the oxygen and was not getting it.</p> <p>On 04/28/2023 at 5:03 PM, an interview was conducted with EI #2, Registered Nurse (RN)/Director of Nursing. When asked if RI #14's Physician's Order to receive Oxygen at 3L/MIN continuously had been followed, EI #2 said no, but stated that all doctor's orders should be followed. She admitted that the concern with not following doctor's orders was that the resident was not receiving his/her prescribed care.</p> <p>Based on observations, interviews, record reviews, review of the Director of Social Services Job Description, review of facility policies titled, Medication Administration General Guidelines and Oxygen Guideline, and review of [NAME] and Perry's Fundamentals of Nursing, the facility failed to ensure:</p> <ol style="list-style-type: none"> 1) Resident Identifier (RI) #1's admission Physician Orders were followed, as RI #1 was admitted with an order for a cardiologist appointment for 4/10/23, that was missed. This affected one of three residents sampled for appointments; and was cited as a result of investigation of complaint/report number AL00043987, 2) licensed nurses did not leave medications unattended at the bedside of RI #2, this affected one of 17 resident's sampled, 3) RI #3's Physician Order for Oxygen Use for 3L(liters)/MIN (minute) via nasal cannula continuously was followed, this affected one of 17 resident's whose orders were reviewed; and 4) provide evidence RI #4's Scopolamine patch was removed and reapplied on 02/13/2023 as ordered by the physician. This deficient practice affected RI #4, one of one resident having a Physicians Order for a Scopolamine patch; and was cited as a result of investigation of complaint/report number AL00043925. <p>Findings include:</p> <ol style="list-style-type: none"> 1) A review of Social Service Job Description, revealed. POSITION DESCRIPTION POSITION TITLE: Social Services Director . Key Responsibilities . 4. Arranges transportation, makes appointments and acts as liaison between all departments, residents' families and outside agencies. <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Diversicare of Riverchase		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 Riverhaven Drive Birmingham, AL 35244	
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>RI #1 was admitted to the facility on [DATE] with a diagnosis of Acute on Chronic Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure.</p> <p>A review of RI #1's discharge orders from the hospital revealed . Recommendations . At discharge . should follow up in CHF (Congestive Heart Failure) clinic on 4/10/23. Discharge Planning: (name of Hospital) CHF Discharge Instructions . CHF clinic 04/10/2023 10:40 .</p> <p>A review of the Order Summary Report for RI #1 revealed . Order Summary APPOINTMENT WITH . CHF CLINIC 4/10/23 at 10:40 AM .</p> <p>On 4/26/23 at 11:50 AM, during an interview with Employee Identifier (EI) #7, Social Service Director she was asked how she found out about resident appointments; she said the Nurse Practitioner (NP) or Director of nursing would tell her, and she did not know about RI #1's appointment. EI #7 was asked why she would not know about the appointment if she was the one who set up transport. EI #7 said once she knew about an appointment, she would set it up. When she was asked about the appointment and realized RI #1 had missed it, she called and rescheduled. EI #7 was asked what the problem could be if a resident missed an appointment. EI #7 said it varies depends on the type of appointment, she recalled the NP telling RI #1's family RI #1 missed the appointment and another was scheduled for the 4/18. EI #7 was asked where the appointment sheet was for 4/18/23; EI #7 said she did not make one, as RI #1's family was taking the resident out of the facility that day which was 4/11/23.</p> <p>On 4/28/23 at 8:00 AM during an interview with EI #9, the admitting nurse she was asked how did the facility get orders for RI #1. she said admit orders were faxed to the facility the day before RI #1 came. EI #9 was asked when was the cardiology appointment made known to the facility; EI #9 said with admission orders so she put it in the facility Physician Orders. When EI #9 was asked when was the appointment to be; she said on 4/10/23 at 10 something in the morning. EI #9 said she did not know if RI #1 went to the appointment or why the appointment was missed. When EI #9 was asked who was responsible for making transport arrangements; she said social service does that if they know about it. EI #9 was asked if the appointment was a doctor's order; she said yes. When EI #9 was asked how doctor's orders were followed if the appointment was missed; she said orders were not followed.</p> <p>On 4/28/23 at 8:20 AM during a follow up interview with EI #7, Social Services, she was asked how did she find out about resident appointments on current or new residents. EI #7 said in the morning meeting they discussed new admits and new orders and it was usually at that time she was told of appointments. EI #7 was asked what she recalled about RI #1 in the morning meeting on 4/6/23. EI #7 said honestly, she could not recall any discussion about an appointment, if she had she would have arranged transport and placed a sheet in the appointment book. EI #7 was asked why was the appointment for RI #1 on 4/10/23 missed. EI #7 said, Oversight. EI #7 was asked how did she find out about appointments. EI #7 said the Nurse Practitioner will call, nurses will call and in morning meetings if it was a new resident. When EI #7 was asked who was responsible for setting up appointments; she said she was and she got the appointment instructions and would arrange for transport. EI #7 said she then placed an appointment sheet in the appointment book; the staff would go to the book and see who had appointments and when and where and have the resident ready. EI #7 was asked what could the concern be in a resident missing an appointment. EI #7 said the problems may vary. When EI #7 was asked if the appointment was a doctor's order; she said yes. EI #7 was asked what was the concern with the appointment being missed; EI #7 said the facility did not follow doctor's orders.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/28/23 at 12:10 PM during an interview with EI #2, the Director of Nursing she said RI #1 had a follow up appointment on the admission orders for the Congestive Heart Failure Clinic. When asked who should have been notified of the appointment EI #2 said she should have told about it in the morning meeting the day after RI #1 was admitted , we discuss new admits and review the orders, and social services would have arranged transportation and placed paper in appointments book. EI #2 said they had determined the appointment was missed. EI #2 was asked why was the appointment missed; she said an oversight on our part. EI #2 was asked if the appointment was a doctors' order; she said yes. When EI #2 was asked how were doctors orders followed if the appointment was missed; she said the orders were not followed.</p> <p>4) Page 311 of Chapter 23 titled Legal Implications in Nursing Practice of [NAME] and PERRY's FUNDAMENTALS OF NURSING, with a copyright date of 2017, documented:</p> <p>. Health Care Providers' Orders . Nurses follow health care providers' orders unless they believe that the orders are in error .</p> <p>RI #4 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Alzheimer's Disease, Adult Failure to Thrive and Encounter for Palliative Care.</p> <p>RI #4's Order Summary Report (Physicians Orders) revealed RI #4 had an order, with a start date of 02/14/2022, for Scopolamine Patch 72 Hour 1 MG (milligram)/3 DAYS Apply 1 patch transdermally every 72 hours for secretion and remove per schedule .</p> <p>On 04/26/2023 at 6:57 PM, the surveyor conducted a telephone interview with RI #4's representative. The resident representative alleged RI #4's Scopolamine patch was off for four days.</p> <p>A review of RI #4's February 2023 e-MAR (electronic Medication Administration Record) revealed on 02/13/2023, there was no evidence RI #4's Scopolamine patch had been removed and a new one applied as ordered by the physician. Further review of the eMAR revealed the next time there was evidence the Scopolamine patch had been replaced was on 02/16/2023, three days later.</p> <p>On 04/28/2023 at 11:55 AM, the surveyor conducted an interview with Employee Identifier (EI) #12, the CNA (Certified Nursing Assistant)/Medication Aide administering medications to RI #4 on 02/13/2023. When asked where there would be evidence RI #4's Scopolamine patch had been removed and a new one applied as ordered by the physician, EI #12 said that would be on the eMAR. The surveyor asked EI #12, looking at EI #4's February 2023 eMAR, did she see evidence RI #4's Scopolamine patch was removed and applied on 02/13/2023. EI #12 said no. The surveyor asked EI #12 how she as a Medication Aide would show the Physicians Orders had been carried out. EI #12 said by documenting on the eMAR.</p> <p>On 04/28/2023 at 6:30 PM, the surveyor conducted an interview with EI 10, the Registered Nurse (RN)/Unit Manager of the unit RI #4 resided on. When asked where there would be evidence RI #4's Scopolamine patch had been removed and a new one applied as ordered by the physician, EI #10 said that would be documented on the eMAR. The surveyor asked EI #10, looking at RI #4's eMAR, did she see evidence the Scopolamine patch was removed and a new one applied on 02/13/2023, EI #10 said no.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, facility document titled POSITION DESCRIPTION for Social Services Supervisor, and facility policy titled Transfer & (and) Discharge the facility failed to ensure an individualized discharge plan of care which was a part of the comprehensive care plan was created for Resident Identifier (RI) #3, RI #10 and RI #16.</p> <p>This affected three of three residents sampled for discharge planning.</p> <p>Findings Include:</p> <p>A review of facility policy titled Transfer & Discharge with an effective date of November 1, 2016, revealed . PROCEDURE . Orientation for Transfer or Discharge . 7. In accordance with Federal and State law, (name of facility) will provide and document sufficient preparation and orientation to the Resident to ensure a safe and orderly . discharge from the Center and will be provided in a form and manner the Resident can understand.</p> <p>A review of facility document titled POSITION DESCRIPTION for Social Services Supervisor signed by Employee Identifier (EI) # 13 on 11/03/2022 revealed .KEY RESPONSIBILITIES . 6. Ascertains potential and develops discharge plans when clients are admitted .</p> <p>RI #3 was admitted on [DATE] with diagnoses that included End Stage Renal Disease. RI #3 was discharged on 12/20/2022.</p> <p>On 04/27/2023 RI #3's Care Conference Person and family reported that they were not informed a final discharge plan.</p> <p>RI #3 did not have an individualized discharge plan of care.</p> <p>RI #10 was admitted on [DATE] with diagnoses that included Infection Following a Procedure, Other Surgical Site, Subsequent Encounter. RI #10 was discharged on 04/25/2023.</p> <p>On 04/26/2023 at 2:45 PM RI #10 Care Conference Person and family reported that they were not informed of final discharge plan or when wheelchair for home would be delivered.</p> <p>RI #10's comprehensive care plan did not include an individualized discharge plan of care.</p> <p>RI #16 was admitted on [DATE] with diagnoses that included Cerebral Infarction Due to Unspecified Occlusion or Stenosis of Right Middle Cerebral Artery. RI #16 was discharged on 04/24/2023.</p> <p>RI #16's comprehensive care plan did not include an individualized discharge plan of care.</p> <p>On 04/26/2023 at 5:00 PM an interview was conducted with EI #11, Minimum Data Set and Care Plan Assistant. EI #11 said EI #4 or EI #13 was responsible for developing resident individualized discharge care plans.</p> <p>(continued on next page)</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/27/2023 at 10:20 AM an interview was conducted with EI #14, Licensed Practical Nurse, Regional Nurse, Unit Manager. EI #14 said EI #4 or EI #13 developed residents' discharge plan of care. EI #14 was asked, discharge planning was the process of creating an individualized discharge care plan, which was part of the comprehensive care plan, who was responsible for creating the individualized discharge care plan. EI #14 replied, EI #4.</p> <p>On 04/27/2023 at 10:40 AM an interview was conducted with EI #4, Director of Care Coordination who said social services was responsible for discharge plan of care and she was not sure what the process included.</p> <p>On 04/27/2023 at 10:50 AM an interview was conducted with EI #13, Social Services Director. EI #13 said he talked to the family and resident to ascertain and develop a discharge plan when residents are admitted . EI #13 did not know who was responsible for developing and updating resident discharge care plan. EI #13 was asked, discharge planning was the process of creating an individualized discharge care plan, which was part of the comprehensive care plan, who was responsible for creating the individualized discharge care plan. EI #13 replied, social services was not doing that and was not aware that it needed to be initiated by social services. EI #13 continued and said that EI #11 developed the comprehensive care plans.</p> <p>On 04/27/2023 at 12:15 PM an interview was conducted with EI #2, Registered Nurse, Director of Nursing. EI #2 said the discharging nurse should provide resident and family with any documentation to clarify and educate the family and resident on discharge, but it could be done better. EI #2 said MDS staff, EI #11, was responsible for developing resident's individualized discharge care plan. EI #2 said it was important to create a discharge plan of care to see if facility was meeting goals to allow resident to progress to other levels of care. EI #2 said RI #3, RI #10, and RI #16 did not have a discharge plan of care developed.</p> <p>*****</p> <p>This deficiency was cited as a result of the investigation of complaint/report number AL00042883.</p>		