STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015032	A. Building B. Wing	06/19/2023

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record reviews, it was determined the facility failed to ensure activities of daily living (ADL) were provided to ensure good grooming for one (Resident #18) of three residents reviewed for ADL care. Specifically, the facility failed to ensure resident #18's fingernails were trimmed. Findings included: On 06/14/2023 at 3:28 PM, the Director of Clinical Operations (DCO) indicated the facility had no policy for the provision of ADL care to include nail care. The DCO stated the facility just provided the needed care. A review of the admission Record indicated the facility admitted Resident #18 on 08/20/2018 with diagnoses that included a Stroke with Left Sided Hemiparesis, Dementia, Contracture to the Left Elbow, and the Need for Assistance with Personal Care. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/20/2023, indicated Resident #18 had a Brief Interview for Mental Status (BIMS) score of 10, indicating the resident had moderate cognitive impairment. The MDS indicated Resident #18 required extensive assistance from staff with personal hygiene. A review of Resident #18's care plan, with a revision date of 03/28/2023, revealed a focus area for Resident #18 that indicated the resident had a physical functioning deficit related to Left Hemiparesis (inability to use the arm and hand). Interventions directed staff to assist the resident with daily care as needed. Observations of Resident #18 on 06/13/2023 at 1:36 PM, on 06/14/2023 at 11:30 AM, and on 06/15/2023 at 9:48 AM revealed the resident's fingernails extended one-quarter to one-half inch beyond the tip of the finger. Resident #18's left hand was contracted (unable to move the extremity due to the joints being in a fixed position) with the fingernails touching the palm of the resident's hand. The edges of the nails appeared rough. During the observation on 06/13/2023 at 1:36 PM an interview with Resident #18 revealed the resident stated their fingernails needed to be trimmed. Certified Nursing Assistant (CNA) #2 was interviewed on 06/15/2023 at 9:12 AM. CNA #2 stated it was the responsibility of the CNA assigned to the resident to keep the resident's fingernails trimmed and clean. CNA #7 was interviewed on 06/15/2023 at 9:34 AM and stated the CNA that was assigned to the resident was responsible for providing nail care as needed. The CNA stated she usually checked residents' (continued on next page)

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fingernails on assigned shower days. CNA #7 stated she had been assigned to care for Resident #18 on 06/12/2023 and on 06/15/2023, but neither of those days was the shower day for the resident. On 06/15/2023 at 9:48 AM, an observation of Resident #18's nails was conducted with CNA #7. CNA #7 stated Resident #18's fingernails were too long, and the fingernails should have been trimmed when the resident was scheduled for a shower. Resident #18 stated the fingernails were long, but they were not digging into (his/her) skin yet. The Administrator was interviewed on 06/16/2023 at 4:48 PM and stated she expected residents' nails to be cleaned and trimmed on a regular basis. An interview with the Director of Nursing (DON) was held on 06/17/2023 at 11:46 AM, and the DON stated his expectations were for nail care to be provided as needed when staff noted nails were long or dirty.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and facility guidelines, the facility failed to implement the facility's guidelines for Elopement. This occurred when Resident #98 was assessed as being at risk of elopement and no individualized plan was established and no interventions were developed to mitigate the risk until after Resident #98 exited the facility without staff's knowledge on 02/06/2023. In addition, the facility also failed to ensure Resident #320, a resident assessed by the facility as an elopement risk, was wearing a WanderGuard on 06/16/2023 as ordered. Further, the facility failed to ensure the facility's staff were checking the placement of Resident #320's WanderGuard every shift, in accordance with the plan developed by the facility following Resident #98's elopement. On 02/06/2023, Resident #98 left the facility without staff's knowledge. A local police officer returned Resident #98 to the facility at 3:45 PM. The officer reported that he/she found the resident approximately two blocks from the facility. In addition, the facility failed to thoroughly investigate the conditions surrounding Resident #98's elopement, as no statements were obtained from the police officer, family members that were visiting at the time of the elopement, and staff that worked the 3:00 PM to 11:00 PM shift. This deficient practice affected Resident #98 and Resident #320, two of three residents sampled for elopement. On 02/06/2023, ten of 31 residents residing on the secured unit were assessed by the facility as at risk for elopement. On 06/16/2023, 15 of 32 residents residing on the secured unit were identified as at risk for elopement. On 06/16/2023 at 9:25 PM, the Administrator, Director of Clinical Operations, Business Office Manager (BOM), and the Minimum Data Set Coordinator (MDSC) were notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Quality of Care, at F689-Free of Accident Hazards/Supervision/Devices. On 06/16/2023 at 9:30 PM the Administrator, Director of Clinical Operations, BOM, and MDSC were provided a copy of the immediate jeopardy template. The immediate jeopardy began on 02/06/2023 and continued until 06/19/2023, when the facility implemented corrective actions to remove the immediacy and prevent further recurrences. Findings included: A review of the facility's Clinical Care System Guidelines on Elopement, dated April 2017, revealed, Purpose To establish a process that identifies risk and establishes interventions to mitigate the occurrence of elopements. Process On admission Newly admitted or re-admitted residents are assessed for elopement risk If an elopement risk is determined an individualized plan is established and intervention is initiated to mitigate that risk When the nurse identifies the intervention it is documented on the care plan and on the caregiver guide . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After admission when a newly identified elopement risk is identified The Risk of Elopement evaluation is completed to determine interventions An individualized plan is established and implemented to mitigate that risk The plan is documented on the care plan and caregiver's guide . If a bracelet alarm is chosen as an intervention there is a plan for monitoring of placement/function . 1. A review of Resident #98's admission Record indicated the facility admitted the resident on 01/27/2023 with diagnoses that included Dementia with other Behavioral Disturbance and Adjustment Disorder with Anxiety. A review of a Clinical Health Status Evaluation, dated 01/27/2023 and completed by the MDSC, indicated Resident #98 was independent with bed mobility, transfers, and walking. The evaluation also indicated the resident was alert, confused, had memory impairment, and was oriented to person but not time or place. A review of the section titled Elopement revealed Resident #98 was physically able to leave the building, was cognitively impaired with impaired decision-making skills, made repetitive statements about going home, and had a history of wandering. The evaluation indicated that if the resident had a history of wandering, staff were to implement care plan. The evaluation further indicated that based on the assessment, Resident #98 was at risk of elopement. At the bottom of the form, the writer was directed to develop a care plan and discuss the risk of elopement with the interdisciplinary team (IDT). Under the narrative portion of the evaluation, the form indicated Resident #98 was to reside on the locked memory care unit. A review of Resident #98's Baseline Care Plan, signed by the MDSC and effective on 01/27/2023, revealed the section titled Elopement was not completed, and did not identify Resident #98's elopement risk or include any interventions addressing their elopement risk. A review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/31/2023, indicated Resident #98 had a Brief Interview for Mental Status (BIMS) score of three of 15, indicating the resident had severe cognitive impairment. The MDS also indicated the resident wandered one to three days during the assessment period. A review of Resident #98's comprehensive care plans, first initiated on 01/30/2023, revealed no care plan had been developed for Resident #98's risk of elopement until 02/06/2023, after Resident #98's elopement from the facility. A review of Resident #98's Progress Notes revealed the following: - a Daily Skilled Nurses Note, dated 01/30/2023 at 4:21 PM, that indicated Resident #98 wandered the hall and rooms, and was asking how to get out of the unit. - a Daily Skilled Nurses Note, dated 01/31/2023 at 10:52 AM, that indicated Resident #98 often asked how to get out of the unit. - a Social Services note, dated 02/04/2023 at 11:17 AM, that indicated Resident #98 had previously (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resided in another facility and had frequent behaviors of wandering in and out of other resident's rooms. The note indicated the previous facility had recommended Resident #98's family place the resident in a secured memory care unit. The note also indicated that while Resident #98 said he/she were ready to leave, they had not demonstrated any exit-seeking behaviors so far. - a Daily Skilled Nurses Note, dated 02/04/2023 at 9:59 PM, that indicated Resident #98 had exit-seeking behaviors. The note did not describe what type of exit-seeking behaviors were exhibited by Resident #98. - a General Note, dated 02/06/2023 at 5:30 PM, that indicated a local police officer returned Resident #98 to the facility at 3:45 PM from an elopement where the resident had walked out of the facility with visiting family members. The police officer reported to the facility the resident had ambulated about two blocks from the facility. The note indicated that a WanderGuard was placed on Resident #98's left ankle. A review of the facility's Investigation Template, dated 02/13/2023, revealed, . it is the belief of this facility that [Resident #98] most likely pushed on the door after it was opened using the keypad. [Resident #98] was fully dressed with [his/her personal bag] on [his/her] shoulder when [he/she] exited so it is also the belief of this facility that someone let [him/her] out the front door thinking that [he/she] was a visitor . The facility's investigation included review of Resident #98's medical record, a body audit on Resident #98, and statements from a floor nurse, Certified Nursing Assistant (CNA) #15, and CNA #16. There were no other interviews or statements, including from the police officer that returned Resident #98 to the facility, family members visiting the facility around the time of the elopement, or staff working the 3:00 PM to 11:00 PM shift. On 06/13/2023 at 9:39 AM, Resident #98 was observed sitting by the exit door of the secured dementia unit with their personal bag in hand. A staff member entered the secured unit, and Resident #98 was observed attempting to leave as the staff member entered the unit. Certified Nursing Assistant (CNA) #15 was interviewed by telephone on 06/15/2023 at 10:00 AM. CNA #15 stated she had worked on the day shift the day Resident #98 eloped. CNA #15 stated that around 2:00 PM on 02/06/2023, Resident #98 was sitting at a table in the dining room eating and drinking snacks. At about 2:30 PM, a resident and that resident's family member were in the dining room, and Resident #98 got up to visit with that resident. At 3:00 PM, the evening shift began to arrive. CNA #15 stated the visiting family member left before evening shift arrived and added that the last time she saw the resident was at 3:00 PM when she was leaving at the end of her shift. The CNA stated no one knew for sure when Resident #98 left the secured unit. CNA #15 stated she received a call about 30 minutes after she left the building on 02/06/2023 asking her about Resident #98 and when she had last seen the resident. CNA #15 stated that prior to Resident #98 leaving the secured unit, the resident had not worn a WanderGuard and could have been mistaken for a visitor. The CNA also stated that prior to Resident #98's elopement, the resident had exit-seeking behavior and would try to get out of the door and say they had to go to Mobile. CNA #15 indicated staff tried to divert the resident by offering snacks and music, and that worked for a while, but when the diversion wore off, Resident #98 continued to try to exit the secured unit. CNA #15 said she did not report RI #98's behavior to charge nurse or management staff because she thought everyone already knew. On 06/15/2023 at 10:15 AM, a telephone interview was held with CNA #16. CNA #16 stated she had worked on the secured unit the day Resident #98 eloped. CNA #16 stated that even prior to the elopement, Resident #98 would walk up and down the hall asking to leave and would go to the exit door and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stand. CNA #16 stated that on 02/06/2023, she saw Resident #98 between 2:30 PM to 2:40 PM in the dining room with another resident. Both residents left the dining room and began walking up and down the hall. CNA #16 stated she left the secured unit at 3:00 PM, and Resident #98 was on the unit when she left. She added she was sure of this because she had been waiting close to the door for the next shift to arrive and would not have let Resident #98 out of the secured unit. CNA #17 was interviewed on 06/15/2023 at 11:10 AM and stated Resident #98 had exit-seeking behaviors, but not daily. CNA #17 stated Resident #98 packed their belongings, stood by the exit door, and would say they needed to go home. Licensed Practical Nurse (LPN) #8 was interviewed on 06/15/2023 at 11:25 AM. LPN #8 stated WanderGuards were used on the secured unit for residents that were exit seeking. LPN #8 stated that at the time of admission, if the facility was alerted a resident had exit-seeking behaviors, a WanderGuard was discussed with the family. She stated that when the elopement assessment indicated a plan of care was needed, she followed those directions and implemented an elopement plan of care. A telephone interview was held with LPN #9 on 06/15/2023 at 12:30 PM, and she stated she had not worked the day Resident #98 eloped. LPN #9 reviewed the 02/04/2023 Progress Note related to exit seeking behaviors and acknowledged she had documented the note. LPN #9 defined Resident #98's exit-seeking behavior as going to the exit door and even rounding up other residents to leave. LPN #9 stated Resident #98's exit-seeking behavior usually occurred after supper when staff cleaned up the dining room, and the resident would gather personal belongings and state they were ready to go. LPN #9 stated that after Resident #98 was in bed, the resident stayed in bed for the entire night. A telephone interview was held with Resident #98's representative, Resident Representative (RR) #36, on 06/15/2023 at 1:01 PM. RR #36 stated the facility had informed him they thought the resident had walked out with other visitors. RR #36 stated Resident #98 had a history of wandering and going out alone, adding that when the resident lived with another family member, the family member would wake up, find the front door open, and Resident #98 was down the street. He stated those behaviors were why the family had chosen a locked unit. RR #36 stated that on admission he/she was very forthcoming about the resident's behavior and told not only the Admissions Liaison (AL) but other nurses and added he/she did not think the facility took Resident #98's flight risk as seriously as they should have. RR #36 stated anyone that saw Resident #98 knew the resident was physically able to get out of the building. The Director of Clinical Education (DCE) was interviewed on 06/15/2023 at 1:39 PM. The DCE stated she was responsible for training new nurses to complete assessments and when to do assessments for residents. She stated if any assessment directed nurses to proceed to care plan, she instructed nurses to make sure there had been a care plan developed for the problem. The DCE stated the nurse that admitted the resident was responsible for initiating the baseline care plan, then the baseline care plan went to the morning clinical meeting, where the problem and care plan would be discussed, and revisions made as needed. The DCE reviewed the baseline care plan and the elopement assessment for Resident #98 and stated that since the admission elopement assessment indicated the resident was at risk of elopement, the nurse should have included a focus area for elopement on the baseline care plan. The DCE also reviewed the comprehensive care plan and stated a care plan for elopement should have been developed prior to the resident's elopement on 02/06/2023. The DCE stated she interviewed Resident #98 who told the her that he/she waited for someone to go out and then followed the person out of the unit and the building. The DCE further stated, after Resident #98 left the secure unit, the receptionist likely thought the resident was just another visitor since Resident #98 left with (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	visitors. The MDSC was interviewed on 06/15/2023 at 2:30 PM and stated that when an elopement assessment indicated a resident was at risk of elopement, the risk should be included on the baseline care plan and then carried to the comprehensive care plan. The MDSC confirmed she completed the admission elopement assessment for Resident #98 on 01/27/2023. The MDSC reviewed the baseline care plan completed on 01/27/2023 and confirmed she had not included elopement on Resident #98's baseline care plan but was unable to recall why she had not included the focus area of elopement. The MDSC reviewed the comprehensive care plan for Resident #98 developed by the facility and confirmed the focus area of elopement had not been added until 02/06/2023, after Resident #98 left the facility without staff's knowledge. The MDSC had no answer for why the comprehensive care plan had not included a focus area for elopement with interventions to mitigate the risk of elopement. The MDSC stated she did not know if having a baseline care plan or comprehensive care plan would have had influence in the resident's ability to elope but indicated a WanderGuard may have made a difference. The MDSC stated the interdisciplinary team (IDT), which consisted of the MDS nurse, the Unit Manager, Director of Nursing, and the Administrator, decided if a resident received a WanderGuard. A review of the medical record for Resident #98 failed to reveal documentation the IDT team had reviewed Resident #98 for a WanderGuard after the resident had been identified as a risk for elopement on 01/27/2023. The AL was interviewed on 06/15/2023 at 3:24 PM and confirmed she was responsible for reviewing records prior to a resident's admission. The AL stated any information she received from the RR during the admission process was shared with the nurse on the hall. The AL stated RR #36 was the person that completed Resident #98's admission paperwork. The AL stated RR #36 stated Resident #98 was an outdoor person and liked to walk but added she did not remember hearing anything about Resident #98 leaving a family member's house at night and going outside. The AL stated she made sure the nurses were aware Resident #98 liked to be outside and liked to walk but could not remember who had been told. A review of Resident #98's medical record revealed there was no documentation that reflected Resident #98's preference to walk or be outside. Dietary Aide (DA) #6 was interviewed on 06/16/2023 at 10:07 AM. DA #6 stated she was not at the facility when RI #98 eloped. DA #6 said she had not received education on elopement policies and protocols after Resident #98 eloped. The Director of Clinical Operations (DCO) was interviewed on 06/16/2023 at 10:44 AM and stated that on 02/06/2023, the day of Resident #98's elopement, an ad hoc (done for a particular purpose as necessary) quality assurance (QA) meeting was held and added she had been a part of that meeting. The DCO stated she had walked in the facility with the police officer and thought the eloped resident was a visitor. On 06/16/2023 at 11:40 AM, the Administrator stated that a resident that triggered for elopement and had exit seeking behaviors should receive a WanderGuard. The Administrator further stated that if a resident had no exit-seeking behaviors, such as pushing on the door, a WanderGuard may not be needed, if the resident resided on the secured unit. An observation and interview were held on 06/16/2023 at 1:06 PM with Front Desk Receptionist (FDR) #24. While standing at the doorway of the dayroom in the secured unit, FDR #24 stated she was unable (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to identify any of the residents in the secured unit. An interview was held with RR #23 on 06/16/2023 at 1:21 PM. RR #23 stated they had not received any instruction from the facility to be careful when leaving to avoid residents following them out. A telephone interview was held on 06/16/2023 at 1:25 PM with the police officer that returned Resident #98 to the facility on [DATE]. The officer stated he thought he had received a call from the community that a person that looked lost passed by a house, but added when he found Resident #98, they were confident in what they were doing. The officer stated he almost let Resident #98 go since there was no reason to detain the resident. The officer stated he searched the resident's personal items, found phone numbers, and called until he reached the RR, who told him where Resident #98 lived. The officer stated he returned the resident to the facility between 3:30 PM and 3:45 PM. The officer stated Resident #98 was found about two to three blocks from the facility or about a quarter of a mile. He was unable to remember exactly where he found the resident. The Director of Nursing (DON) was interviewed on 06/16/2023 at 1:37 PM. The DON stated he had been unaware Resident #98 was out of the building until the police officer brought the resident back to the facility. The DON stated if the resident triggered at risk for elopement, then he expected elopement to be included on the baseline care plan and on the comprehensive care plan. The DON stated decisions to place WanderGuards were made by the IDT. The DON stated the reason the investigation had not included family members was because no particular family member had been identified. He stated he had spoken to family members about elopement risks but had no documentation as evidence of the conversations. The DON stated it was probably an oversight that the investigation did not include a statement from the police officer that brought Resident #98 back to the facility. The DON stated it was not the practice of the facility to give visitors the code to enter and exit the secure unit, which meant staff had to push in the code to open the door. The DON stated staff were asked who opened the door, but no staff admitted they were the one that had let Resident #98 out of the unit. The DON stated that although Resident #98's elopement happened around 3:00 PM, which was at the time of shift change, he was unable to give a reason the 3:00 PM to 11:00 PM staff were not asked for witness statements. The DON stated the police officer told him Resident #98 was found in a neighborhood. He was not given an exact address or location. The DON stated he was unable to recall if family members of other residents in the secured unit were educated on not allowing residents to follow them out. During a follow-up interview with the DON on 06/16/2023 at 4:17 PM, the DON stated he had no documentation that he had spoken with family members about the elopement on 02/06/2023 to find out if any of those family members had noted the resident leaving the facility with them. The DON stated the sign on the facility's front door that cautioned visitors about letting residents out was placed on the front door on 02/06/2023, but there was not a sign placed on the secured unit door because staff were supposed to let people out and staff were expected to stop residents from exiting the secured unit. The Administrator was interviewed on 06/16/2023 at 4:57 PM and stated she would have expected to see Resident #98's elopement risk care planned on the baseline care plan to mitigate the resident's elopement risk and would have also expected the elopement care plan to be included on the comprehensive care plan. The Administrator stated that prior to Resident #98's 02/06/2023 elopement, when a resident was placed in the secured unit, staff thought the door was secure. Additionally, the Administrator indicated the door from the lobby to the outside would keep residents inside the facility. The Administrator stated that prior to Resident #98's elopement, WanderGuards were not used in the secured unit. The Administrator stated the expectation was for family members to receive education (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	including being careful that no resident was following them out, and if they were unsure if the person leaving the secured unit was a visitor or a resident, to ask a staff member. 2. A review of the facility's four-point plan, executed after Resident #98's elopement on 02/06/2023, revealed, Staff to check the battery and the proper placement and functioning of all Code Alert bracelets [WanderGuards] every shift and daily respectively. A review of the admission Record for Resident #320 indicated the facility admitted the resident on 06/09/2023 with diagnoses that included Dementia with Mood Disturbance and Unspecified Psychosis. On 06/12/2023, an Elopement Risk Evaluation was completed and indicated that although Resident #320 ambulated with a cane, the resident asked to go home, and based on the assessment, was determined to be at risk of elopement. A review of Resident #320's physician's orders revealed an order, dated 06/13/2023, to check WanderGuard for function every night. There were no orders to check for placement of the WanderGuard until 06/16/2023, when an order to check the placement of the WanderGuard every two hours was added. A review of Resident #320's comprehensive care plans revealed a Focus of I am at risk for elopement, initiated on 06/13/2023. On 06/13/2023, this care plan directed staff to check the resident's WanderGuard to make sure it was working properly. On 06/16/2023, the care plan was revised to direct staff to check the placement of the resident's WanderGuard every two hours, and if Resident #320 removed the WanderGuard, then 1:1 (one on one) observation should be initiated, and the Administrator and Director of Nursing were to be notified. A review of Resident #320's Progress Notes revealed a General Note, dated 06/13/2023 at 10:41 AM, that indicated a WanderGuard had been placed on Resident #320's left ankle due to the resident being an elopement risk. A review of the Progress Notes for Resident #320 from 06/13/2023 through 06/16/2023 revealed no documentation of the resident removing their WanderGuard and no identification of alternative interventions to keep Resident #320 safe. On 06/16/2023 between 1:03 PM and 1:10 PM, observations were made of residents on the secured unit and Resident #320 was not wearing a WanderGuard. Certified Nursing Assistant (CNA) #16 was interviewed on 06/16/2023 at 1:32 PM and confirmed Resident #320 did not have a WanderGuard on their left leg. CNA #16 stated she did not know why the resident was not wearing the WanderGuard and acknowledged the resident was supposed to have a WanderGuard. The DON was interviewed on 06/16/2023 at 4:17 PM and stated Resident #320 had removed his/her WanderGuard. An interview was held with Licensed Practical Nurse (LPN) #25 on 06/16/2023 at 5:58 PM. The LPN stated she had reassessed Resident #320's elopement status on 06/12/2023 because she thought the initial assessment had not been completed. The LPN stated Resident #320 received the WanderGuard because the resident looked like a visitor, the resident was new, and staff had no knowledge of the resident's personality or if the resident would try to elope. LPN #25 stated Resident #320 made comments (continued on next page)

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	015032	A. Building B. Wing	06/19/2023

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	about leaving and going home or to a family member's but had not pushed or pulled on the secured unit exit door. LPN #25 stated she was not sure exactly when Resident #320 pulled their WanderGuard off, but to the best of her knowledge, it had been off since Tuesday (06/14/2023) or Wednesday (06/15/2023). LPN #25 stated she had reported to the DON about Resident #320 taking the WanderGuard off, and the DON told her Resident #320 required reassessing due to not actively exit seeking and not wanting to wear the WanderGuard. LPN #25 was unsure if she had documented anything about Resident #320 taking the WanderGuard off but indicated the checks for the WanderGuard placement should be on the medication administration record (MAR). A review of Resident #320's Medication Administration Record [MAR] and Treatment Administration Record [TAR] for June 2023 revealed no information related to the WanderGuard placement checks. The DON was interviewed on 06/16/2023 at 6:09 PM and stated he found out Resident #320 had removed their WanderGuard on 06/14/2023 and had asked LPN #25 to place the WanderGuard back on the resident and report back if the resident removed the WanderGuard again. The DON stated LPN #25 had not reported back to him, and he had not followed up with the LPN. The DON stated he would have expected documentation to explain why Resident #320 had been reassessed three days after admission and would have expected documentation that indicated the resident would not keep the WanderGuard on. The DON stated he had no interventions documented that would keep the resident safe after the removal of the bracelet. The DON stated nurses were expected to check the function and placement of the WanderGuard every shift, and documentation should be on the MAR. The DON stated he was unaware the WanderGuard check for Resident #320 had not been completed. This deficient practice was cited as a result of complaint/report #AL00043300. ********** On 06/19/2023 at 8:33 AM, the facility submitted an acceptable Removal Plan which included the following: 1. Resident #98 Actions: Resident #98, upon return to the center, was placed on one-to-one supervision that was documented on a resident observation form until a Wander-Guard was placed on the resident to ensure Resident #98's risk for elopement was reduced by the use of the departure alert system (Wander-Guard). The WanderGuard was checked for placement and functionality by the Director of Nursing Services (DNS) on 02/06/2023 and then every shift by charge nurse. The DNS completed a full body assessment upon the resident's return to the center, with no injury noted. A Nurse Practitioner was consulted, who assessed the resident to ensure the resident was without injury. Neurological checks were completed, and laboratory samples were obtained by a charge nurse on 02/06/2023. Resident #98's risk assessment was updated, and their care plan was reviewed and updated. The Medical Director and Responsible Party were notified of the event and a new plan of care was developed to include the use of a WanderGuard. During Clinical Start up, the Interdisciplinary Team (IDT) reviews Monday thru Friday the Elopement Risk Assessments completed on admission/readmission and for any quarterly assessments or significant change assessments to ensure the baseline care plan/comprehensive care plan reflects that the residents required interventions as identified on the Elopement Risk Assessment. 2. The Charge Nurses on each unit immediately completed a physical check to ensure all current resident were safe in facility on 02/06/2023. The Administrator and DNS ensured all residents with a physician order for a WanderGuard had a WanderGuard in place and the WanderGuard was functioning 02/06/2023. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.On 02/06/2023, an immediate investigation was initiated by the Administrator to determine how Resident #98 was able to get outside. This investigation was finished on 02/13/2023. It was the belief of this facility that Resident #98 most likely pushed on the entrance door to the memory care after it was opened using the keypad. 4.On 02/06/2023, the Director of Nursing Services audited the elopement books to assure pictures and care plans were up to date to assure inclusion of all at-risk residents. Three residents were in the elopement book; all three had wander guards and care plans in pictures in the elopement book. 5.On 02/06/2023, all exits doors were checked by the Maintenance director to ensure the doors opened and closed properly. All doors were noted to be secured and functioning properly. The four wander guard doors are checked weekly and documented in Direct Supply TELS. The maintenance director checked 11 exterior doors and the entrance door to Memory care unit by using the keypad, opening the door, and watching the door close and then once the door closed, the maintenance director attempted to re-open the door to make sure it re-locked. The finding of this check was that for all 11 exterior doors and the entrance to the memory care unit, the keypads worked, the doors unlocked, opened, and closed, and relocked, and the closure mechanism worked. The WanderGuard apparatus was checked on the two exterior doors and two interior doors on 02/06/2023 by using a WanderGuard bracelet and walking up to the door to validate that the alarms sound, the door remains locked, and the door does not unlock until the code is entered. The facility has 11 passcode-protected exterior doors, two exterior doors located at the admissions entrance and the main entrance have WanderGuard and are also passcode-protected. Since 02/06/2023. The 11 passcode-protected exterior doors were checked daily. Each check validated that all 11 exterior doors and the entrance to the memory care unit that the keypads worked, the doors unlocked, opened, and closed, and relocked, and the closure mechanism worked. All doors passed inspection. Since 02/06/2023, the WanderGuard apparatus was checked weekly on the two exterior doors and two interior doors on 02/06/2023 by using a WanderGuard bracelet and walking up to the door to validate that the alarms sound, the door remains locked, and the door does not unlock until the code is entered. 6. On 02/06/2023, education was initiated by the Administrator regarding elopement guidelines. A continuation of education, to include elopement guidelines, was conveyed to Licensed Nursing, Certified nursing assistants, facility administrative staff including contracted dietary, housekeeping, and therapy staff by the DNS/Assistant Director of Nursing. Carefully closing doors and locking after entry and exit was included in the education 02/06/2023 provided to the facility staff including dietary, housekeeping, and therapy staff. Staff were informed that any resident with exit-seeking behaviors was to be reported to t[TRUNCATED]

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on resident record review, interviews, and review of the facility guidelines for Pain Management, the facility failed to ensure nursing staff sought an order for treatment for ice therapy for one (Resident #169) of one residents reviewed for concerns of pain. Findings included: A review of a facility guideline titled, Pain Management, dated January 2021, revealed the purpose was To provide guidelines for consistent evaluation, management and documentation of pain in order to provide maximum comfort and enhanced quality of life. The guideline further revealed The nurse develops a plan of care for pain management based on findings from the evaluation with consideration of non-pharmacological interventions. The guideline indicated, The following is a list of non-pharmacological interventions that may be employed to manage pain either alone or as an adjunct to/with medications as needed. The list included Hot/Cold packs. A review of an admission Record indicated the facility admitted Resident #169 on 01/06/2023 with diagnoses that included Aftercare Following Joint Replacement Surgery, Osteoarthritis of the Knee, Fibromyalgia (a disorder that affected muscles and soft tissue), and an Artificial Knee Joint. A review of a 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/08/2023, revealed Resident #169 had a Staff Assessment for Mental Status (SAMS) score of 0, which indicated the resident was independent in making decisions regarding tasks of daily life. The assessment revealed the resident required extensive assistance of two staff members for bed mobility, transfers, toilet use, and bathing, required extensive assistance of one staff member for dressing and personal hygiene, required assistance of two staff members for walking in their room. A review of Resident #169's Baseline CarePlan, initiated on 01/06/2023, revealed the resident had barriers to transition that included pain management. The care plan indicated the resident had two incisions to the left knee related to surgery and pain at the surgical site. The interventions directed staff to administer pain medications as ordered and monitor for effectiveness and to document results and notify the physician for additional interventions. During a phone interview on 06/14/2023 at 2:58 PM, Resident #169 said they requested ice for their knee after knee surgery but was told a physician order was needed. Resident #169 said they were not provided ice therapy for their knee that night. A review of Progress Notes dated 01/06/2023 at 7:15 PM, revealed Resident #169 underwent a left total knee arthroplasty on 01/03/2023. Per the note, the resident and a family member were upset that ice therapy required an order by a physician. The note indicated the resident considered leaving against medical advice due to issues surrounding ice therapy and medical equipment and physical therapy not being present upon the resident's arrival. The note indicated Resident #169 had swelling of the left knee. A review of Resident #169's medical record revealed no evidence a physician order for ice therapy was sought by staff from 01/06/2023 through 01/07/2023. Resident #169's January 2023 Medication Administration Record (MAR) documented a pain level of four out of ten, on 01/06/2023 at bed time. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 06/15/2023 at 2:42 PM, Registered Nurse (RN) #26 stated she did not remember Resident #169. She said if ice therapy were ordered, she would provide it. She said if a patient asked for ice therapy and did not have an order for it, she would have sought an order for it. During an interview on 06/15/2023 at 1:52 PM, Licensed Practical Nurse (LPN) #4 stated residents required an order for ice therapy. She said if Resident #169 asked for ice therapy at night, an order could have been sought for it that night. During an interview on 06/15/2023 at 1:36 PM, RN #29 said she was the Director of Nursing (DON) at the time of Resident #169's stay at the facility, and she remembered discussing the resident during a morning meeting. She said she did not know why Resident #169 was not provided ice for their knee, since staff could have sought an order for it the night the resident was admitted . During an interview on 06/16/2023 at 4:52 PM, the DON said he was not the DON during Resident #169's stay at the facility. He indicated he expected that, if a resident needed ice therapy for their knee, a nurse would seek an order. He said the facility always had a physician on call. During an interview on 06/17/2023 at 3:00 PM, the Administrator stated if a resident requested ice therapy for their knee after knee surgery, she expected staff to get an order for ice therapy to assist with a resident's comfort. This was cited as a result of the investigation of complaint/report number AL00042995.