STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Boaz	600 Corley Avenue Boaz, AL 35957

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** .Based on interview, record review, and facility document and policy review, the facility failed to protect the resident's right to be free from verbal abuse perpetrated by staff for 2 (Resident #56 and Resident #39) of 11 sampled residents reviewed for abuse. Findings included: A facility policy titled, Abuse, Neglect, Misappropriation, Exploitation Policy, effective 01/2019, indicated, Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws. The policy also indicated, Verbal abuse: May be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. The policy also specified, Mental Abuse: is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation.1. An admission Record revealed the facility admitted Resident #56 on 04/26/2021. According to the admission Record, the resident had a medical history that included diagnoses of anxiety disorder, mood disorder, and adjustment disorder with anxiety. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/31/2023, revealed Resident #56 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated Resident #56 required limited assistance for bed mobility and transfers and exhibited no behavioral symptoms. According to the most recent quarterly MDS with an ARD of 04/14/2025, the resident had no short or long-term memory problems and had a BIMS score of 15, which indicated the resident remained cognitively intact.Resident #56's Care Plan Report included a focus area, revised on 04/14/2022, that indicated the resident had a physical functioning deficit related to mobility impairment, range of motion limitations to bilateral lower extremities, and a self-care impairment. Interventions directed staff to provide extensive assistance with locomotion on and off the unit, bed mobility, toileting, and transfers.A printed report from the Alabama Department of Public Health Online Incident Reporting System revealed an allegation of verbal abuse was reported to the state agency on 09/16/2023 at 11:10 AM. The report indicated the involved resident was Resident #56 and the alleged perpetrator was Certified Nursing Assistant (CNA) #5. According to the report, Resident #56 reported the allegation to Registered Nurse (RN) #22 (the weekend supervisor) on 09/16/2023 at 10:20 AM, and RN #22 reported the allegation to the Director of Nursing (DON) on 09/16/2023 at 10:23 AM. Resident #56 informed RN #22 that on 09/15/2023 at 9:00 PM, the resident asked CNA #5 for assistance to bed, and the CNA told the resident she would assist after she took a five-minute break. Twenty-five minutes later, CNA #5 had not returned, so Resident #56 went to look for her. Resident #56 stated they got into a loud discussion in the hallway and that CNA #5 called the resident a smart [expletive]. According to the report, CNA #5 was placed (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on administrative leave and an investigation was initiated.A facility document titled Investigation Template, dated 09/16/2023, revealed an alleged incident of staff-to-resident verbal abuse that occurred on Friday, 09/15/2023, was reported to the weekend supervisor. The Investigation Template revealed Resident #56 alleged that, on 09/15/2023 at 9:00 PM, CNA #5 did not return to assist the resident to bed as promised, and when the resident found CNA #5 and asked them why they had not returned to help, CNA #5 began screaming at the resident, using curse words, and called the resident a smart [expletive]. A typed witness statement, dated 09/16/2023 and signed by Resident #56, indicated the resident stated they asked CNA #5 to assist them with getting into bed, but CNA #5 stated she was going on break and would return in five minutes to assist the resident to bed. The statement indicated the resident stated, I waited and waited and, after about 25 minutes, went to look for CNA #5. When Resident #56 found CNA #5 and asked her where she had been, CNA #5 screamed at the resident, You will not talk to me like that and that the discussion escalated from there. The statement indicated the screaming continued down the hallway and some curse words ([expletive]) were used. The resident reported that at one point, CNA #5 got in the resident's face and called the resident a smart [expletive] and stated, you're not going to talk to me like a dog or like trash. The statement indicated at this point, Resident #56 stated they were exhausted and just wanted to go to bed. The resident asked again for CNA #5 to put them to bed, but CNA #5 initially refused. The statement indicated CNA #5 eventually assisted the resident to bed.A typed witness statement, dated 09/16/2023 and signed by Resident #97, revealed the resident heard Resident #56 ask CNA #5 to assist them to bed, and CNA #5 stated she was going to take a break and would be back in five minutes. According to Resident #97's statement, Resident #56 waited 25 minutes then stated they were tired of waiting and went to find CNA #5. The statement indicated Resident #97 heard Resident #56 and CNA #5 screaming as they came down the hallway and that, as they approached the room, CNA #5 called Resident #56 a smart [expletive], and stated that Resident #56 was not going to talk to her like a dog. The statement indicated Resident #97 asked them to please not fight and noted that Resident #56 was upset and shaking. Resident #56 stated they wanted to go to bed and be done, and CNA #5 initially refused but eventually assisted Resident #56 to bed. The statement indicated CNA #5 and Resident #56 then made up and apologized to each other.A handwritten witness statement, dated 09/16/2023 and signed by CNA #5, indicated that on the night of 09/15/2023, I had not had a break, so I took my break. I did not even take a full break. The statement indicated when CNA #5 returned from break, Resident #56 started attacking me and the CNA explained that she was on lunch break, and the conversation escalated from there. Further review of the facility's Investigation Template dated 09/16/2023 revealed that RN #22 and former Administrator #33 conducted a follow-up interview with CNA #5 on 09/20/2023. When asked to clarify how Resident #56 attacked the CNA, CNA #5 stated the resident just came at me and started asking the CNA where she had been and why she had not returned to assist the resident to bed. The CNA informed RN #22 and former Administrator #33 that, I was already having a bad day when I came in and [Resident #56] just pushed me over the edge. The CNA acknowledged telling Resident #56 that the resident did not have to be a smart [NAME] but did not recall calling the resident a smart [expletive].The facility's Investigation Template dated 09/16/2023 indicated Unit Manager #9 was interviewed during the facility's investigation and stated she heard yelling in the hallway but thought it was CNAs being too loud so had done some education with the staff. The template also indicated 13 residents who resided in the area where CNA #5 provided care were interviewed during the facility's investigation, and no residents voiced concerns regarding their care or how they were treated. The template indicated CNA #5 was terminated for failure to treat a resident with dignity and respect and inappropriate (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavior/failure to adhere to facility standards. The template also indicated Resident #56's care plan was updated to direct staff to assist the resident to bed by 8:00 PM.A Progressive Discipline Form, dated 09/20/2023 and signed by former Director of Nursing (DON) #32, former Administrator #33, and CNA #5, indicated the facility's investigation determined that CNA #5 failed to treat a resident with dignity and respect and that a decision had been made to terminate the CNA's employment. The form indicated the CNA was placed on administrative leave on 09/16/2023 and was terminated on 09/20/2023.On 06/10/2025 at 8:50 AM, the surveyor attempted to contact CNA #5 for a telephone interview. The number had been disconnected and was no longer in service. During an interview on 06/10/2025 at 9:10 AM, the Administrator stated he had no other telephone contact information for CNA #5.On 06/10/2025 at 9:00 AM, the surveyor attempted to contact Resident #97, who had been discharged , for a telephone interview. There was no answer and no voice mail service available to enable a message to be left.On 06/10/2025 at 10:20 AM, Resident #56 was in their room and stated they did not want to talk. The resident stated staff were good to them, they had no concerns, and no one was abusive toward them. When asked about the incident involving CNA #5, the resident stated they did not want to answer any more questions.On 06/11/2025 at 2:59 PM, Resident #56 stated they did not like anyone to come in their room other than the CNAs. The resident stated they felt safe in the facility and were not abused. The resident indicated they would report it if they felt they were abused and stated they did not want to speak to any surveyors.During an interview on 06/12/2025 at 10:26 AM, RN #22 stated CNA #5 and Resident #56 had a verbal altercation on 09/15/2023 and were cursing at each other. During an interview on 06/13/2025 at 3:26 PM, the Administrator stated he was not the facility's Administrator at the time the incident occurred between Resident #56 and CNA #5. He stated he expected staff to treat all residents with dignity and respect and never abuse them. During an interview on 06/13/2025 at 4:00 PM, the Director of Nursing (DON) stated she expected the staff to treat the residents with respect and dignity, and abuse was not tolerated. 2. An admission Record indicated the facility admitted Resident #39 on 11/13/2018 and most recently readmitted the resident on 10/15/2024. According to the admission Record, the resident had a medical history that included diagnoses of unspecified mild dementia, adjustment disorder with depressed mood, and age-related physical debility.A quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 04/14/2025, indicated Resident #39 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required setup or clean-up assistance with eating and supervision or touching assistance with walking.Resident #39's Care Plan Report included a focus area that indicated the resident had an impaired neurological status and was at risk for cognitive decline related to dementia with behavioral disturbance and epilepsy. Interventions directed staff to assist the resident with activities of daily living (ADLs) and mobility as needed (initiated 11/26/2018); provide pleasant interaction to reassure the resident when confused (initiated 11/26/2018); and provide verbal reminders to assist the resident with orientation (initiated 11/26/2018).Review of a printed report from the Alabama Department of Public Health Online Incident Reporting System, revealed an allegation of staff-to-resident verbal abuse was reported to the state agency for Resident #39. The report indicated staff became aware of the allegation on 03/18/2024 at 1:15 PM and reported the allegation to the Director of Nursing (DON) on 03/18/2024 at 1:18 PM. The report indicated the allegation was reported to the state agency on 03/18/2024 at 2:28 PM. According to the report, the Health Information Management and Coding (HIMC) employee reported that the involved resident was Resident #39 and the alleged perpetrator was Licensed Practical Nurse (LPN) #14. The report indicated the HIMC employee heard the resident ask for ketchup and that LPN #14 responded using (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	profanity. The report indicated LPN #14 was placed on administrative leave and an investigation was initiated.An Investigation Template, dated 03/18/2024, revealed the HIMC employee reported that she was in her office and overheard a resident ask LPN #14 for some ketchup. The LPN asked the resident to wait. The resident again asked for ketchup, and LPN #14 stated, No, I haven't, but let me stop what the [expletive] I'm doing and get you some. The Investigation Template identified the resident as Resident #39 and indicated upon interview, the resident did not recall anyone cursing but stated they got ill with the resident when the resident asked for ketchup and told the resident it was ugly to hog all the ketchup. An undated typed witness statement indicated Resident #39 was asked if anyone was ugly to the resident when they asked for ketchup, and the resident stated, Yes, she got ill with me. The statement indicated the resident did not know who the staff member was but stated the staff member told them, it was ugly of me to hog all the ketchup. The statement indicated the resident expressed that they felt safe in the facility.A handwritten witness statement, dated 03/18/2024 and signed by LPN #14, indicated Resident #39 came out into the hall and yelled at LPN #14, asking where their ketchup was and if LPN #14 had the ketchup. The statement indicated LPN #14 informed the resident she did not have the ketchup then went down the hall, got four packets of ketchup, and provided them to Resident #39.An undated typed witness statement from Certified Nursing Assistant (CNA) #25 indicated she did not hear Resident #39 ask for ketchup but did hear LPN #14 say that she had to take some ketchup to Resident #39. The statement indicated LPN #14 made an additional comment but CNA #25 was not sure if she said, before I kill or kick [Resident #39] or before [Resident #39] kicks or kills me. The statement indicated CNA #25 denied ever having heard LPN #14 cuss at a resident before but had heard LPN #14 cursing on the phone.A typed witness statement, dated 03/20/2024 and signed by Regional Dietary (RD) Staff #34, indicated the employee heard something regarding ketchup but could not remember what was said. RD Staff #34 indicated, I believe it was something along the lines of [expletive] ketchup and let me take this ketchup to [Resident #39] before [resident] kicks me.A typed witness statement, dated 03/20/2024 and signed by RD Staff #35, indicated the employee thought she heard, Let me go get this ketchup to this resident. RD Staff #35 thought LPN #14 either stated, before I kill [resident] or [resident] kills me but was not sure what was said. The statement indicated RD Staff #35 reported that the other RD staff member (RD Staff #34) thought LPN #14 said kick.Further review of the facility's investigation documentation revealed residents who resided in rooms near Resident #39's room were interviewed to determine if they heard anyone talking ugly or using curse words, and all residents interviewed denied having heard the exchange between Resident #39 and LPN #14; the residents also stated the staff were good to them and responded to their requests and that they felt safe in the facility. The Investigation Template dated 03/18/2024 indicated LPN #14 was terminated for failure to treat a patient with dignity and inappropriate behavior/failure to adhere to facility standards. Additionally, the Investigation Template indicated abuse education was provided to facility staff.A Lecture (In-service) form, dated 03/23/2024, indicated training on Abuse and When to Report was provided to facility staff on 03/23/2024 at 2:00 PM. The attached attendance roster contained the signatures of 42 staff members who attended the training.During an interview on 06/11/2025 at 8:57 AM, Resident #39 stated the facility staff were good. The resident stated they felt safe in the facility, had no concerns with the staff, and did not recall anyone being unkind or using any bad language toward them. As the interview continued, at 9:05 AM, the resident stated the staff are all real nice.During an interview on 06/12/2025 at 11:57 AM, the HIMC employee stated on 03/18/2024, she was in her office with the door open and heard LPN #14 use curse words in responding to a resident. She left her office and saw that LPN #14 was standing outside Resident #39's room. She (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she went straight to the DON to report the incident, then the DON took over the investigation. She stated she had never heard LPN #14 curse at a resident before but had heard her curse during general conversations off the unit.During an interview on 06/12/2025 at 3:00 PM, Resident #39's family member stated they had no concerns with the facility, were aware of the abuse allegation, and did not feel it harmed the resident in any way.During an interview on 06/13/2025 at 3:26 PM, the Administrator stated he expected staff to treat all residents with dignity and respect and never abuse them.During an interview on 06/13/2025 at 4:00 PM, the DON stated she expected the staff to treat the residents with respect and dignity. She stated abuse was not tolerated. 3. An “admission Record” revealed the facility admitted Resident #300 on 10/30/2024. According to the admission Record, Resident #300 had a medical history that included chronic, peripheral venous insufficiency and a nonthermal blister on the right lower leg. An admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/2024, indicated Resident #300 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed that Resident #300 had no behaviors or rejection of care during the assessment’s lookback period. The MDS indicated that the resident was occasionally incontinent of urine and frequently incontinent of bowel. The MDS revealed Resident #300 required substantial/maximal assistance from staff for toilet transfers and was dependent on staff for toileting hygiene. A review of the facility abuse investigation file for Resident #300 revealed that an initial report of abuse was submitted to the State Department of Public Health on 11/02/2024 at 12:58 PM. The report revealed that the incident type was verbal abuse. The report revealed the name of the resident involved was Resident #300, with the alleged perpetrator listed as Certified Nursing Assistant (CNA) #23. The report revealed that Registered Nurse (RN) #22 reported to the Administrator that Resident #300 accused CNA #23 of verbal abuse. The report revealed an allegation was also made by Family Member (FM) #37, Resident #300’s family member. The “Investigation Template” indicated Resident #300 stated that they “mashed” their call light to be toileted and when CNA #23 entered the room she asked what they needed and told the resident “You need to learn how to use the urinal;” however, when the resident explained to CNA #23 that they were not able to, CNA #23 replied with “Then you need to learn how to use your diaper.” The template revealed, Resident #300 stated CNA #23 then left the room refusing to help the resident. Per the template, Resident #300 stated they did not get any help for a couple of hours and rang their light again because they needed clean bed linens. The template revealed Resident #300 stated CNA #23 came back into the room and said she was not changing the resident’s linen and that the resident needed to learn how and that the resident would respect her. Per the template, Resident #300 stated they asked CNA #23 to plug in their phone charger and CNA #23 started throwing things around their room and told the resident “No, the phone charger is none of my business.” The template revealed Resident #300 had told CNA #23 to get out of their room and not come back. Per the template, Resident #300 stated CNA #23 had walked out but came back later and stood in the resident’s doorway arguing with them. The template revealed Resident #300 stated that they had FM #37 on the phone with them during the incidents and FM #37 heard how CNA #23 treated them. Per the template, CNA #23 stated that the resident had made a racial slur and after that she only had one other interaction with the resident and there were two other CNAs in the room because the nurse instructed her to make sure she took someone with her. The template revealed the facility determined that there had been no evidence to substantiate the alleged abuse. A telephone interview was held with RN #36 on 07/03/2025 at 4:17 PM. RN #36 stated she was assigned (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to care for Resident #300 on 11/01/2024 during the 7:00 PM to 7:00 AM shift. RN #36 stated she had passed the resident’s room and saw CNA #24 sitting in a chair and added CNA #23 was also in the room. RN #36 stated Resident #300 kept asking over and over who they were, and the CNAs would not answer the resident. She stated that the resident became more agitated and anxious. RN #36 stated that this had occurred a few hours into the shift. RN #36 stated she had reported the incident to the Director of Nursing (DON) but was unsure when she had reported the incident. RN #36 described the interaction as CNA #23 and CNA #24 just being cruel, bordering on abuse, and added it was mental abuse. A review of the staffing schedule and assignment sheet for 11/01/2024 indicated CNA #24 and RN #36 had been assigned to care for Resident #300. CNA #24 was interviewed on 07/03/2025 at 3:47 PM. CNA #24 had been assigned to care for Resident #300 during the 7:00 PM to 7:00 AM shift on 11/01/2024. CNA #24 stated she had been in the room with CNA #23 during provision of care for Resident #300. CNA #24 denied hearing CNA #23 say anything rude or mean to the resident and denied they had refused to assist the resident. CNA #23 was interviewed on 07/03/2025 at 5:36 PM. CNA #23 denied refusing to assist Resident #300 or telling the resident to void in their brief. The Administrator and DON were interviewed on 07/04/2025 at 10:30 AM and stated they had been unaware of the potential mental abuse to Resident #300 by CNA #23 and CNA #24 reported by RN #36. A telephone interview was held with FM #37 on 07/08/2025 at 10:45 AM. FM #37 stated they had been on the phone with Resident #300 and had been disturbed by how the CNA had spoken to the resident. FM #37 stated they had heard the resident ask repeatedly who the CNAs were and there had been no response back to the resident although they could hear the CNAs “yapping” at the resident. FM #37 stated later that same evening they called the resident again and the resident had told them that while one (CNA) sat in a chair the other (CNA) had stripped the resident naked and changed their clothing in front of the other person. FM #37 stated she had called the facility that same night (11/01/2024) and had spoken to someone about what had been heard while they were on the phone with Resident #300. FM #37 stated that on 11/02/2024, they went to the facility, spoke to a staff member, and informed that person that CNA #23 was not to take care of Resident #300. FM #37 stated that on Monday, 11/04/2024, she spoke to the Administrator about what they had overheard on the phone. FM #37 stated after they had reported the CNA, multiple staff and residents thanked her for reporting the CNA and added one resident had described CNA #23 as mean and spiteful. FM #37 stated they had overheard the CNA tell Resident #300 to toilet themself and void in the brief if they were unable to independently toilet themself. FM #37 stated the incident had been reported to two staff members on Friday night, 11/01/2024, but had been unable to recall the names of the staff. FM #37 stated that since the incident, Resident #300 had passed away. FM #37 stated what was overheard on the phone, directed toward Resident #300, was verbal and mental abuse.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interview, record review, facility document review, and facility policy review, the facility failed to ensure residents were free from any physical restraint not required to treat the resident's medical symptoms, which affected 1 (Resident #299) of 1 resident reviewed for use of restraints. Findings included: A facility policy titled, Restraint, dated 11/28/2016, revealed, Upon determination a patient/resident presents with medical symptoms that may require a restraint, they are evaluated for the least restrictive device. This evaluation includes physical considerations, medical issues and possible restraint alternatives such as referrals to rehab [rehabilitation] therapy or mental health services. An admission Record indicated the facility admitted Resident #299 on 03/22/2024. According to the admission Record, the resident had a medical history that included a diagnosis of Alzheimer's disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/2024, revealed Resident #299 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required partial/moderate assistance with chair/bed-to-chair transfers, and with walking 10 feet. Per the MDS, the resident required substantial/maximal assistance with walking 50 feet with two turns, and with walking 150 feet. The MDS indicated the resident used a walker and a wheelchair. The MDS did not indicate the use of a restraint. Resident #299's Care Plan Report, included a focus area initiated 04/04/2024, that indicated the resident was at a high risk for falls related to confusions, deconditioning, gait/balance problems, hypotension, poor communication/comprehension, psychoactive drug use, wandering, and an unawareness of safety needs. Interventions directed staff to anticipate and meet the resident's needs (initiated 04/04/2024) and ensure the resident's walker was within reach (initiated 05/17/2024). Interventions also indicated that the resident was new to the memory unit, was confused, and became disoriented easily and directed staff to reorient the resident to their surroundings and staff and to remind the resident to ask for assistance with all activities of daily living (initiated 04/09/2024.) The Care Plan Report included a focus area dated 03/28/2024, that indicated the resident had received hospice care. Interventions directed staff to coordinate the resident's care plan with hospice (initiated 03/28/2024). The Care Plan Report did not indicate the use of a restraint. A facility document titled, Investigation Template, dated 10/02/2024, indicated Resident #299 was observed with a gait belt around their wheelchair, around the resident's waist, and buckled behind the resident's back. The document indicated that this was observed by an occupational therapist and the Director of Care Coordination (DCC). An Alabama Department of Public Health Online Incident Reporting System document submitted by the facility, dated 10/02/2024, indicated that Resident #299 was observed sitting in their wheelchair with a gait belt around the resident's waist and buckled around the wheelchair, behind the resident's back. The document indicated the Maintenance Director removed a side of the wheelchair and removed the gait belt from the chair. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/12/2025 at 11:29 AM, Certified Nursing Assistant (CNA) #26 stated there were no restraints used in the Memory Unit and only therapy staff used gait belts. CNA #26 stated that a hospice CNA told her that the hospice CNA was the one who put the gait belt on Resident #299. During an interview on 06/12/2025 at 12:10 PM, the DCC stated that she was in the Memory Unit on 10/02/2024. She stated that Resident #299 had something fastened to them. During an interview on 06/13/2025 at 3:38 PM, the Administrator stated the facility did not use restraints, and gait belts were not generally used in the Memory Unit. He stated that his expectation was that residents were free of restraints.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/04/2025
NAME OF PROVIDER OR SUPPLIER Diversicare of Boaz		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Corley Avenue Boaz, AL 35957	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interview, record review, and facility document and policy review, the facility failed to ensure staff reported allegations of staff-to-resident abuse to administration within two hours for 2 (Resident #37 and Resident #300) of 11 sampled residents reviewed for abuse.Findings included:

A facility policy titled, “Abuse, Neglect, Misappropriation, Exploitation Policy,” effective 01/2019, indicated, “7. Reporting and Response: Alleged violations/violations will be reported to the Administrator, designee immediately. Immediately reporting all alleged violations to the Administrator, designee, state agency, adult protective services and to all other quired agencies (e.g. [for example], law enforcement when applicable) within specified timeframes.” The table column titled, “Alleged Violations,” and row titled “When” revealed, “All alleged violations - Immediately but not later than 1. 2 hours if the alleged violation involves abuse or results in serious bodily injury. 2. 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury.”

1. An “admission Record” indicated the facility initially admitted Resident #37 on 12/13/2024 and readmitted the resident on 05/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of peripheral vascular disease, mood disorder due to a known physiological condition with depressive features, and generalized anxiety disorder.

An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2025, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment.

Resident #37’s “Care Plan Report” included a focus area, revised 06/10/2025, that indicated the resident was on pain medication therapy due to disease processes associated with peripheral vascular disease (PVD), chronic obstructive pulmonary disease (COPD), and chronic kidney disease (CKD). Interventions directed staff to administer analgesic medications as ordered by the physician, monitor/document side effects and effectiveness every shift, and to monitor and report adverse reactions.

Resident #37’s “Order Summary Report” revealed an order for tramadol hydrochloride (tramadol HCL, a narcotic analgesic) oral tablet 50 milligrams (mg), give one tablet by mouth every four hours as needed for pain, started 05/23/2025.

A “Medication Administration Record [MAR],” dated 05/2025, indicated on 05/29/2025 at 4:41 AM Resident #37 received 50 mg tramadol administered by Unit Manager #9.

A nurse’s “Progress Note” dated 05/29/2025 at 10:40 AM, indicated that Resident #37 stated two certified nursing assistants (CNAs) who worked the night shift entered the resident’s room to answer the call light, and the resident requested a pain pill. The Progress Note indicated Resident #37 stated that in about 10 minutes the resident pressed the call light again, the same two CNAs answered the call light, the resident again requested a pain pill, and one of the CNAs stated, “There are only two of us for two halls, so we will give it to you when we want to give it to you.” The Progress Note indicated when the nurse came to give Resident #37 pain medication, the resident revealed that one of the CNAs stated, “If you give us [expletive], we are

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/04/2025
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	going to give you [expletive].” The Progress Note indicated Resident #37 stated they had not been changed the entire shift until near the end of the shift; they were treated roughly, and their legs had been hurt. The Progress Notes indicated bruises were found on Resident #37’s left shin and behind the right knee. An “Alabama Department of Public Health Online Incident Reporting System” facility report, submitted 05/29/2025 at 12:17 PM, indicated the category “Abuse-Physical,” involved Resident #37, and listed alleged perpetrators CNA #1 and CNA #2. The report indicated that the date and time that staff became aware of the incident was 05/29/2025 at 10:40 AM; however, an undated, handwritten statement from Unit Manager #9 revealed that after a CNA reported to her that Resident #37 needed a pain pill, she took the resident a pain pill, and the resident stated, “those girls talked ugly to me.” During an interview on 06/12/2025 at 8:05 AM, Unit Manager #9 stated Resident #37 reported that CNA #2 talked ugly to the resident one night. Unit Manager #9 stated CNA #2 reported to her that Resident #37 wanted a pain pill, and when Unit Manager #9 went to administer the pain pill she saw CNA #2 coming out of the resident’s room and CNA #2’s arm was bleeding. Unit Manager #9 stated that CNA #2 told her that Resident #37 scratched her. Unit Manager #9 stated that she took the pain pill in to Resident #37, and the resident stated that CNA #2 talked ugly to them. Unit Manager #9 stated that she was administering the medication on the night shift from 7:00 PM to 7:00 AM. During the interview Unit Manager #9 reviewed the MAR and confirmed that she administered medication for pain to Resident #37 on 05/29/2025 at 4:41 AM. Unit Manager #9 stated that she did not report what was told to her by the resident right away because it was early in the morning but that she reported it to the Administrator and the Director of Nursing (DON) later that morning when they came in. During an interview on 06/12/2025 at 9:52 AM, the DON stated that she expected staff to report incidents immediately, even if they thought it might not be abuse. The DON stated that she first became aware of the incident involving Resident #37 during the morning meeting on 05/29/2025 at about 10:00 AM. During an interview on 06/12/2025 at 10:09 AM, the Administrator, who also served as the Abuse Coordinator, stated he expected staff to immediately notify him when they became aware of abuse. The Administrator stated on 05/29/2025 around 4:00 AM Unit Manager #9 learned that Resident #37 stated staff had talked ugly to them, and he expected the nurse to report it to him. The Administrator stated on 05/29/2025 at 10:40 AM, during the morning meeting, Resident #37 asked to speak to someone in charge and reported that staff had been rough with them and hurt their legs. 2. An “admission Record” revealed the facility admitted Resident #300 on 10/30/2024. According to the admission Record, Resident #300 had a medical history that included chronic, peripheral venous insufficiency and a nonthermal blister on the right lower leg. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/05/2024, indicated Resident #300 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed that Resident #300 had no behaviors or rejection of care during the assessment’s lookback period. The MDS indicated that the resident was occasionally incontinent of urine and frequently incontinent of bowel. The MDS revealed Resident #300 required substantial/maximal assistance from staff for toilet transfers and was dependent on staff for toileting hygiene. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility abuse investigation file for Resident #300 revealed that an initial report of abuse was submitted to the State Department of Public Health on 11/02/2024 at 12:58 PM. The report revealed that the incident type was verbal abuse. The report revealed the name of the resident involved was Resident #300, with the alleged perpetrator listed as Certified Nursing Assistant (CNA) #23. The report revealed that Registered Nurse (RN) #22 reported to the Administrator that Resident #300 accused CNA #23 of verbal abuse. The report revealed the allegation was made by Family Member (FM) #37, Resident #300’s family member. The report indicated that CNA #23 was placed on administrative leave pending the outcome of the investigation. The “Investigation Template” indicated that during rounds, Resident #300 had informed the Workforce Management Coordinator (WMC) about the alleged verbal abuse. The template indicated the WMC had reported the allegation of verbal abuse to RN #22, who in turn, reported the allegation of abuse to the Director of Nursing (DON) and the Administrator. The template outlined the facility’s investigation, which included interviews with Resident #300, FM #37, and staff that worked on the night of the incident. The template revealed the facility determined that there had been no evidence to substantiate the alleged abuse. The investigation file revealed the final report was submitted to the State Agency on 11/08/2024 at 11:12 PM. A review of the employee statements revealed an undated, unsigned statement had been obtained from CNA #20. The statement indicated that CNA #20 had worked on the 3:00 PM to 11:00 PM shift on 11/01/2024. The statement indicated that when CNA #20 returned to work on 11/02/2024, RN #36 told CNA #20 that FM #37 was coming to the facility to speak about the way CNA #23 had spoken to Resident #300. The statement indicated at that time CNA #20 reported the conversation to the supervisor (identified later as RN #22) and the manager on duty (MOD who was identified as WMC). CNA #20 was interviewed on 07/03/2025 at 1:39 PM. She stated she always worked the day shift and was not in the facility when the incident occurred. CNA #20 stated her shift had started on 11/02/2024 at 7:00 AM, but stated she typically arrived a few minutes early. She stated that on arrival to work on 11/02/2024, RN #36 reported to her that FM #37 was coming to the facility to speak about the way CNA #23 had spoken to the resident. CNA #20 stated RN #36 had worked the previous night (11/01/2024) on the 7:00 PM to 7:00 AM shift and that while the shift ended at 7:00 AM, the nurse did not always leave at 7:00 AM. Registered Nurse (RN) #36’s timecard revealed RN #36 had worked on 11/01/2024 and had clocked out on 11/02/2024 at 7:22 AM. A review of the facility schedule for 11/01/2024 revealed RN #36 had been assigned to care for Resident #300. The DON was interviewed on 07/03/2025 at 3:10 PM. The DON reviewed the facility’s investigation file related to the incident regarding Resident #300’s allegation of verbal abuse. The DON stated she expected staff to report allegations of abuse or any suspicious activity immediately. The DON reviewed the statement given by CNA #20 and stated if RN #36 had reported any suspicious activity to CNA #20 before she left the faciity on [DATE] around 7:00 AM, then the incident between CNA #23 and Resident #300 should have been reported before 11:53 AM. The DON stated someone should have questioned how CNA #23 had spoken to Resident #300, and she should have been notified. The DON stated that according to the statement by CNA #20, the allegation of verbal abuse was late being reported to the state agency. A telephone interview was held with RN #36 on 07/03/2025 at 4:17 PM. She stated she was assigned to care for Resident #300 on 11/01/2024 during the 7:00 PM to 7:00 AM shift. RN #36 stated she had passed the resident’s room and saw CNA #24 sitting in a chair and added CNA #23 was also in the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room. RN #36 stated Resident #300 kept asking over and over who they were, and the CNAs would not answer the resident. She stated that the resident became more agitated and anxious. RN #36 stated she had reported the incident to the DON but was unsure when she had reported the incident. She stated she had again reported the incident on Saturday, 11/02/2024, before she left the facility and confirmed she had reported the incident to CNA #20. RN #36 described the interaction as CNA #23 and CNA #24 just being cruel, bordering on abuse, and added it was mental abuse. The Administrator was interviewed on 07/03/2025 at 4:36 PM. The Administrator reviewed the statements from staff and stated if RN #36 had observed abuse he expected her to report the abuse as she had been trained to do. The Administrator and DON were interviewed on 07/04/2025 at 10:30 AM and stated that they had been unaware of the mental abuse to Resident #300 as reported by RN #36. The Administrator and DON stated RN #36 should have reported the incident.

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Respond appropriately to all alleged violations.

Based on interview, record review, and facility document and policy review, the facility failed to immediately put protective measures in place to prevent further potential abuse following an allegation of staff-to-resident verbal abuse for 1 (Resident # 37) of 11 sampled residents reviewed for abuse. The facility also failed to have evidence that allegations of abuse and/or neglect were thoroughly investigated for 2 (Resident #300 and Resident #14) of 11 sampled residents reviewed for abuse. Findings included:

1. A facility policy titled, “Abuse, Neglect, Misappropriation, Exploitation Policy,” effective 01/2019, indicated: “Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws.” The policy revealed, “The following protocol has been established in the event of an allegation of abuse: 1. Protection,” which included, “If the suspected perpetrator is a team member, the Administrator/Director of Nursing or designee shall place the team member on immediate investigatory suspension while completing the investigation.”

An “admission Record” indicated the facility initially admitted Resident #37 on 12/13/2024 and readmitted the resident on 05/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of peripheral vascular disease, mood disorder due to a known physiological condition with depressive features, and generalized anxiety disorder.

An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2025, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment.

Resident #37’s “Care Plan Report” included a focus area, revised 06/10/2025, that indicated the resident was on pain medication therapy due to disease processes associated with peripheral vascular disease (PVD), chronic obstructive pulmonary disease (COPD), and chronic kidney disease (CKD). Interventions directed staff to administer analgesic medications as ordered by the physician, monitor/document side effects and effectiveness every shift, and to monitor and report adverse reactions.

A nurse’s “Progress Note” dated 05/29/2025 at 10:40 AM, indicated Resident #37 stated two CNAs that worked the night shift entered the resident’s room to answer the call light, and the resident requested a pain pill. The Progress Note indicated Resident #37 stated that in about 10 minutes the resident pressed the call light again, the same two CNAs answered the call light, the resident again requested a pain pill, and one of the CNAs stated, “There are only 2 of us for 2 halls so we will give it to you when we want to give it to you.” The Progress Note indicated when the nurse came to give Resident #37 pain medication, the resident revealed one of the CNAs stated, “If you give us [expletive], we are going to give you [expletive].” The Progress Note indicated Resident #37 stated they had not been changed the entire shift until near the end of the shift; they were treated roughly, and their legs had been hurt. The Progress Notes indicated bruises were found on Resident #37’s left shin and behind the right knee.

Resident #37’s “Order Summary Report” revealed an order for tramadol hydrochloride (tramadol HCL, a narcotic analgesic) oral tablet 50 milligrams (mg), give one tablet by mouth every four hours as needed for pain, started 05/23/2025.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A “Medication Administration Record [MAR],” dated 05/2025, indicated on 05/29/2025 at 4:41 AM Resident #37 received 50 mg tramadol administered by Unit Manager #9. An “Alabama Department of Public Health Online Incident Reporting System” facility report, submitted 05/29/2025 at 12:17 PM, indicated the category “Abuse-Physical,” involved Resident #37, and listed alleged perpetrators CNA #1 and CNA #2. The report indicated that the date and time that staff became aware of the incident was 05/29/2025 at 10:40 AM; however, an undated, handwritten statement from Unit Manager #9 revealed that after a CNA reported to her that Resident #37 needed a pain pill, she took the resident a pain pill, and the resident stated, “those girls talked ugly to me.” During an interview on 06/12/2025 at 8:05 AM, Unit Manager #9 stated Resident #37 reported that CNA #2 talked ugly to the resident one night. Unit Manager #9 stated CNA #2 reported to her that Resident #37 wanted a pain pill, and when Unit Manager #9 went to administer the pain pill she saw CNA #2 coming out of the resident’s room and CNA #2’s arm was bleeding. Unit Manager #9 stated that CNA #2 told her that Resident #37 scratched her. Unit Manager #9 stated that she took the pain pill in to Resident #37, and the resident stated that CNA #2 talked ugly to them. Unit Manager #9 stated that she was administering the medication on the night shift from 7:00 PM to 7:00 AM. During the interview Unit Manager #9 reviewed the MAR and confirmed that she administered medication for pain to Resident #37 on 05/29/2025 at 4:41 AM. Unit Manager #9 stated that she did not report what was told to her by the resident right away because it was early in the morning but reported it to the Administrator and the Director of Nursing (DON) later that morning when they came in. Unit Manager #9 stated that, when she reported the concern to the Administrator and the DON, CNA #1 and CNA #2 had already completed their shifts. An untitled facility document containing timecard details for CNA #1 indicated that on Wednesday, 05/28/2025, CNA #1 clocked-in at 11:02 PM and clocked-out the morning of 05/29/2025 at 7:01 AM. An untitled facility document containing timecard details for CNA #2 indicated that on Wednesday, 05/28/2025, CNA #2 clocked-in at 10:50 PM and clocked-out the morning of 05/29/2025 at 7:00 AM. During an interview on 06/12/2025 at 9:52 AM, the DON stated she expected staff to report incidents immediately, even if they thought it might not be abuse. The DON stated staff were to intervene immediately, to prevent any further harm. The DON stated that once an incident of abuse was reported, they placed staff on administrative leave pending an investigation. The DON stated that she first became aware of the incident involving Resident #37 during the morning meeting on 05/29/2025 at about 10:00 AM, and CNA #1 and CNA #2 were put on administrative leave immediately after the incident was reported to her. During an interview on 06/12/2025 at 10:09 AM, the Administrator, who also served as the Abuse Coordinator, stated if there was an allegation of abuse staff were to protect the resident at all costs, immediately notify him, and any alleged perpetrator was to be placed on administrative leave pending the investigation. 2. A facility policy titled, “Abuse, Neglect, Misappropriation, Exploitation Policy,” effective 01/2019, indicated: “Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws.” The policy revealed, “6. Investigation,” included, (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

“The Administrator, or designee will oversee the center in conducting an internal investigation against any violation/alleged violation of abuse, neglect, exploitation, injury of unknown source, misappropriation of resident property, or involuntary seclusion and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within five working days of the incident or according to state law. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions. The investigation will include, but is not limited to the following:” “Interviews of all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations (Factual information should be documented, no assumptions, speculations or conclusions within the interviews).” Further review revealed, “All material and documentation of the pertinent data to the investigation is collected, maintained, and safeguarded by the center.”

An “admission Record” revealed the facility admitted Resident #300 on 10/30/2024. According to the admission Record, Resident #300 had a medical history that included chronic, peripheral venous insufficiency and a nonthermal blister on the right lower leg.

An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/05/2024, indicated Resident #300 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed that Resident #300 had no behaviors or rejection of care during the assessment’s lookback period. The MDS indicated that the resident was occasionally incontinent of urine and frequently incontinent of bowel. The MDS revealed Resident #300 required substantial/maximal assistance from staff for toilet transfers and was dependent on staff for toileting hygiene.

A review of the staffing schedule and assignment sheet for 11/01/2024 indicated Certified Nursing Assistant (CNA) #24 and Registered Nurse (RN) #36 had been assigned to care for Resident #300.

A review of the facility’s abuse investigation file for Resident #300 revealed that on 11/02/2024 an allegation of verbal abuse had been made by Resident #300 and Family Member (FM) #37, Resident #300’s family member. The file revealed the allegation of verbal abuse was submitted to the state agency on 11/02/2024. The file revealed the final report was submitted to the state agency on 11/08/2024. The file revealed the investigation completed by the facility included statements from staff that had been assigned to work in the facility on 11/01/2024, starting with the 3:00 PM to 11:00 PM shift. The investigation file included an interview with Resident #300 and CNA #23, who was the alleged perpetrator. The investigation file revealed there were no documented interviews with CNA #24, who had worked with CNA #23. Further review also revealed that there were no documented interviews with FM #37 or with RN #36.

A telephone interview was held with RN #36 on 07/03/2025 at 4:17 PM. She stated she was assigned to care for Resident #300 on 11/01/2024 during the 7:00 PM to 7:00 AM shift. RN #36 stated she had passed the resident’s room and saw CNA #24 sitting in a chair and added CNA #23 was also in the room. RN #36 stated Resident #300 kept asking over and over who they were, and the CNAs would not answer the resident. She stated that the resident became more agitated and anxious. RN #36 described the interaction as CNA #23 and CNA #24 just being cruel, bordering on abuse, and added it was mental abuse. RN #36 stated she did not remember giving a written statement to the facility about the alleged incident.

CNA #24 was interviewed on 07/03/2025 at 3:47 PM. CNA #24 stated she had not given a statement to

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility about the incident because the incident had nothing to do with her. The Administrator was interviewed on 07/03/2024 at 4:36 PM. The Administrator stated that CNA #24 was probably interviewed, and it was just not written. The Administrator stated he had probably interviewed RN #36 and CNA #24 over the telephone, and the interviews had not made it to the investigation file. The Administrator stated he had spoken with FM #37 but had not written a statement. The Administrator had no reason as to why the documentation of interviews had not been completed. 3. A facility policy titled, “Abuse, Neglect, Misappropriation, Exploitation Policy,” effective 01/2019, indicated: “Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations (to include injuries of unknown source, mistreatment and involuntary seclusion) in accordance with Federal and State Laws.” The policy revealed the section titled, “Definitions,” included, “Injuries of Unknown Source: When both of the following criteria are met: the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g. [exempli gratia, for example] the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.” The policy revealed, “6. Investigation,” included, “The Administrator, or designee will oversee the center in conducting an internal investigation against any violation/alleged violation of abuse, neglect, exploitation, injury of unknown source, misappropriation of resident property, or involuntary seclusion and report the results of the investigation to the enforcement agency in accordance with state law including the state survey and certification agency within five working days of the incident or according to state law. Investigations will be prompt, comprehensive and responsive to the situation and contain founded conclusions.” An “admission Record” indicated the facility admitted Resident #14 on 09/19/2018. According to the admission Record, the resident had a medical history that included diagnoses of sarcopenia (loss of muscle and strength), vitamin deficiency, and osteoarthritis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/07/2025, revealed Resident #14 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident required substantial/maximal assistance with rolling left and right on their bed, going from lying on their back to sitting on the side of a bed, chair/bed-to-chair transfers, and with toilet transfers. Resident #14’s “Care Plan Report,” included a focus area initiated 09/25/2018, and revised on 01/23/2023, that indicated the resident had a physical functioning deficit and was at risk for contractures related to mobility impairment, self-care impairment due to sarcopenia, muscle weakness, osteoarthritis, and Alzheimer’s disease. Interventions directed staff to inspect skin with care and report reddened areas, rashes, bruising, or open areas to the charge nurse (initiated 10/04/2018); and provide one to two-person extensive assistance with bed mobility and toileting/incontinence care (initiated 06/06/2019 and revised 09/03/2020). The Care Plan Report included a focus area initiated 09/25/2018 and revised 04/16/2025, that indicated Resident #14 was at risk for complications related to aspirin therapy. Interventions directed staff to observe the resident for signs/symptoms of bleeding, blood in urine, bruising, and petechiae (tiny red or purple spots on the skin due to bleeding under the skin). A facility document titled, “Investigation Template,” indicated that on 04/10/2025 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015063	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/04/2025
NAME OF PROVIDER OR SUPPLIER Diversicare of Boaz		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Corley Avenue Boaz, AL 35957	

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #14 was noted to have “discoloration” on their right wrist, hand, and thumb. The document revealed the Administrator was notified. The document indicated that the Administrator, along with the Director of Nursing (DON), assessed and interviewed the resident. Per the document, when the resident was asked where the bruising was from, the resident stated, “The girls was [sic] helping me up.” The document revealed that the Administrator opened his hand, and the resident laid their hand into his hand, and the Administrator asked the resident if that was how “the girls” helped the resident up, and the resident said, “Yes.” The document indicated that Licensed Practical Nurse (LPN) #11 notified the resident’s family member (FM), FM #10. The document indicated that the source of the discoloration was not observed by any person, but the discoloration had been explained by the resident. The document indicated that the discoloration was not suspicious “because of the extent of the injury and the location.” Per the document, on 04/11/2025, a Department of Human Resources (DHR) employee came to the facility and reported to the DON that FM #10 had reported to them that they thought Resident #14 may have been abused due to the bruising on the resident’s right hand. The document indicated that administrative staff reported the allegation to the state survey agency and conducted an investigation. The document indicated that a “body audit” was completed, and an X-ray was ordered, which revealed no fractures. The document indicated that staff were interviewed, and statements were obtained, as well as other residents residing in the same hall as Resident #14. The Investigation Template indicated that the facility could not find evidence of abuse. The facility’s investigation of the incident included documentation of staff interviews that revealed the following questions: - “Have you witnessed anyone abuse [Resident #14]?” - “Have you provided care to [Resident #14]?” - “How does [Resident #14] react when care is being provided to [Resident #14]?” The facility’s investigation revealed no evidence the facility had investigated the root cause of the resident’s bruising, including documentation of questioning staff about the resident’s bruising, or how the resident was transferred/repositioned. During a telephone interview on 06/12/2025 at 9:08 AM, FM #10 stated they receive a call about the bruising on the resident’s hands/wrist. FM #10 stated they came to the facility and spoke to the Administrator and DON. FM #10 stated they thought the Administrator or DON would look into the bruising to see if the bruising was from where staff were pulling the resident to reposition them in a way that could have caused the bruising but was not sure if they looked into what actually happened. FM #10 stated they had not heard from the Administrator or DON as to whether they had investigated the bruising. During a telephone interview on 06/13/2025 at 1:45 PM, Certified Nursing Assistant (CNA) #12 stated the resident told her that a staff member grabbed their wrist when they were picking them up. CNA #12 stated she reported it because the resident said their thumb hurt. She stated she did not remember any bruising. During a telephone interview on 06/12/2025 at 9:47 AM, LPN #11 stated that on 04/10/2025, a CNA told her about bruising on Resident #14’s hand/wrist, so she checked the resident for injuries and saw bruising. She stated it was on the resident’s inner wrist, close to the resident’s (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015063	A. Building B. Wing	07/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Boaz	600 Corley Avenue Boaz, AL 35957

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thumb, and it was the size of a quarter or a little larger. During an interview on 06/13/2025 at 3:26 PM, the Administrator stated Resident #14 told him that the girls were trying to help the resident sit up. He stated that he asked the resident if staff raised them up by the resident’s hands, and the resident’s answer was “yes.” The Administrator stated that he did not suspect abuse, so he did not report it until 04/11/2025 when DHR staff reported to them that FM #10 alleged abuse related to the bruising. The Administrator stated he thought the bruising was from staff repositioning the resident in their bed, but looking back, he should have looked into why they were repositioning or moving the resident in a way to cause bruising. The Administrator stated staff should never reposition the residents by their wrists or hands, and he expected the staff to transfer or reposition residents in a way that did not cause any injuries or bruising.