STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015148	A. Building B. Wing	04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Arab	235 Third Street SE Arab, AL 35016

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 0689 Level of Harm - Minimal harm or potential for actual harm 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 observation, interview, record review and policy review, the facility failed to assess and implement interventions after one of three sampled resident reviewed for falls in sample of 20 residents (Resident Identifier (RI) #54) fell on [DATE] and sustained a laceration to her forehead. The facility failed to obtain vital signs, document in nurse's notes, and complete a thorough post fall assessment to determine the root cause of the fall, and determine if new interventions were necessary, putting the resident at risk for additional falls. Findings include: Review of the facility's policy titled Falls Clinical Care System Guidelines for Falls, dated February 2017, revealed the purpose was, to establish a process that identifies risk and establishes interventions to mitigate the occurrence of falls. After a fall occurred, the following steps were to be taken, in pertinent part: -The post fall evaluation is completed to assist in developing interventions to prevent future falls. -The fall event and intervention are recorded on the resident's care plan. -The fall prevention interventions are initiated. -The interdisciplinary team (IDT) reviews the post fall investigation to find causal factors and summarizes the team recommendations for interventions. If the fall occurred from the chair/wheelchair, the policy directed staff to: -Evaluate reason for fall in order to choose appropriate intervention - ex (example) reaching, attempting to transfer or standing, leaning too far forward, sliding out of chair, etc. Review of the admission Face Sheet, undated, in the electronic medical record (EMR) under profile, revealed the resident was admitted to the facility on [DATE]. Diagnoses included ataxic gait, unsteadiness of feet, other abnormalities of gait and mobility, dementia, and muscle weakness. Review of the Annual Minimum Data Set (MDS) dated 06/20/20 revealed the resident had a Brief Interview for Mental Status score of 99 indicating the resident was unable to complete the test. The staff interview for mental status revealed the resident had long and short-term memory impairment and was (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2021
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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 - Minimal harm or potential for actual harm Residents Affected - Few	severely impaired in cognitive skills for daily decision making. Under the Behavior Section, the resident was not identified with any behaviors. Under the Functional Status Section, the resident was assessed as requiring extensive assistance for bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene. The resident had not walked in the room or in the corridor or unit. The resident had no impairment in range of motion and used a wheelchair for ambulation. Under the Fall Section, the resident had not experienced any falls since admission or the last prior assessment. Review of the care plan with the most recent revision date of 09/09/19 (printed on 04/13/21) revealed the resident was at risk for falls related to medications, impaired cognition with confusion, generalized weakness, poor safety awareness, and use of the wheelchair for mobility. The care plan identified falls occurring on 12/12/18 - fall with no injury, 03/03/19 - a fall with no injury, and 09/08/19 - fall with laceration to forehead. The goal was for no fall related injuries to occur through the next review. Interventions included in pertinent part: placing in common area when up in the wheelchair as the resident would allow initiated on 03/03/19, bed in low position initiated on 04/25/18, call light within reach and items within easy reach initiated on 04/25/18, keeping the environment well-lit and free of clutter initiated on 4/25/18, therapy referral as needed initiated on 04/25/18. The fall that occurred on 04/07/21 was not documented on the care plan; new interventions were not documented on the care plan when it was reviewed on 04/13/21. The policy directed staff to document the fall on the care plan and new interventions on the care plan. Review of the 1088 Fall form (Post Fall Evaluation) dated 04/07/21 at 12:38 PM revealed the fall occurred in the resident's room on this date at this time. The Incident Description read, The nurse was called to the resident's room by another staff member. Upon entering the (sic) I observed the resident lying on her stomach with her head under the roommate's wheelchair and bedside table. Prior to the fall resident was noted in her wheelchair with the (sic) her bedside table in front of her. Under Immediate Actions taken, the form read, Resident assessed for s/s (signs and symptoms) of injury, laceration noted to forehead, cleansed wound and applied non-adherent pad and wrapped with kerlix. Resident transferred to (Hospital name) for further eval (evaluation) and treatment. MD (Medical Doctor) and family notified, The resident was documented with an injury to the top of the scalp, with an occasional moan or groan and low-level speech with a negative quality. The resident was sad, frightened, or frowning, tensed, distressed, pacing body language. Multiple headings were blank; no information was documented as follows: Injuries Report Post Incident under Injury Type and Injury Location, Level of Pain, Level of Consciousness, Mobility, Mental Status, Predisposing Environmental Factors, Predisposing Physiological Factors, and Predisposing Situation Factors. The activity at the time of the fall was chair to floor. The resident was unable to explain what happened. The resident was documented with a history of falls. The activity that occurred prior to the fall was not identified. The patient evaluation section that included documentation of vital signs of blood pressure, temperature, and oxygen saturations was blank (not filled out). The fall was documented as being witnessed. Under the Witness Section, an RN reported walking down the hall when she answered a call light and the resident told her that her roommate was on the floor. The RN notified the charge nurse. The statement from the charge nurse (who completed the 1088 form) indicated she was called to the room by another staff member and upon entering, saw the resident lying on her stomach with her head under her roommate's wheelchair and bedside table. The box indicating care plan interventions were in place prior to the fall to help determine post fall interventions was blank. Interventions/Recommendations Post Fall and Immediate Actions sections were blank. The box indicating caregivers were updated on the interventions was blank. There was a lack of evidence a root cause analysis was done to determine the cause of 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fall, to determine what the resident was doing at the time of the fall in order to identify appropriate interventions to implement in response. Review of Nurses' Notes revealed no entry on 04/07/21, the date of the fall. The only note on 04/08/21 at 8:41 PM revealed the resident was resting in bed. No mention of the fall or injury was documented. Review of a Nurse's Note dated 04/09/21 was the first note indicating the resident fell. The note revealed the resident was noted with baseline confusion. The sutures were intact to the resident's forehead and she had bruising to her eyes from the recent fall. Vital signs were stable and she was in no acute distress. Review of Physician's Orders dated 04/07/21 directed nurses to Monitor laceration to forehead for s/s of infection for eight days and to remove sutures to the resident's forehead on 04/16/21. In an interview on 04/12/21 at 1:09 PM with RI #67, who was RI #54's roommate, revealed RI #54 had a recent fall in their shared room in which RI #54 hit her head on RI #67's over bed table. RI #67 stated she was in the room at the time the fall occurred, but the curtain was pulled between the beds so she did not witness the fall. RI #67 stated RI #54 fell and hit her forehead on the bottom bar of RI #67's overbed table that was located on her side of the privacy curtain. RI #54 was in bed eating lunch during the conversation with RI #67 on 04/12/21 at 1:09 p.m. RI #54's bed was in a low position and the call light was in reach. No other fall interventions were observed to be in place. RI #54 did not respond to the surveyor's introduction or conversation. RI #54 was observed with a horizontal laceration several inches in length with sutures across her forehead between the bridge of her nose and hair line. During the survey, from 4/12/21 to 4/14/2021, observations of the resident showed she remained in bed in the low position with the call light in place. The resident was not observed up in a chair during the remainder of the survey so there was no opportunity for observation to assess if any changes were made to provide safety for the resident. During an interview on 04/14/21 at 12:12 PM EI #19, Licensed Practical Nurse (LPN) stated she was working when R#54's fall occurred on 04/07/21. She stated she had just come on duty and another nurse notified her R#54 was on the floor. R#54 had been sitting in her wheelchair in her room. She was not sure what happened. She found R#54 on the floor. She stated the resident was sent to the emergency room for sutures to her forehead. She stated the resident was in the hospital a few hours and then returned to the facility. Neuros were completed upon her return. She reviewed the post fall assessment with the surveyor and stated the resident was oriented to person only and was a high fall risk and had other falls. She looked for documented interventions and stated the resident had a low bed and there was a therapy referral made on 04/13/21 and that the resident had been seen by the Occupational Therapist related to falling out of the wheelchair. During an interview on 04/15/21 at 1:45 PM. EI #20, the Occupational Therapist (OT) stated RI #54 fell out of her wheelchair so she went to assess her/wheelchair on 04/13/21. She stated the resident had behaviors and did not want to get out of bed so she could not assess her that day. She said she could do the evaluation at a later date. She stated RI #54 was usually up in the wheelchair quite a bit, at least a few times a week prior to falling face forward out of the wheelchair and hitting her face/forehead. She stated she would determine if the resident needed positioning devices. During an interview on 04/15/21 at 4:45 PM EI #11, LPN stated RI #54 needed assistance with activities of daily living (ADLs), except she could feed herself. She stated the resident did not like to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get up sometimes and could get agitated. EI #11 stated the fall should have been documented in a Nurse's Note and the SBAR (communication tool - situation, background, assessment, recommendation). She stated the facility protocol was to write a Nurse's Note, complete the SBAR documentation and document for 72 hours in Nurse's Notes the resident's status post fall. Also, the Post fall evaluation (1088 Fall form) should be completed as well. EI #11 reviewed the documentation in the medical record with the surveyor and stated the first mention of the fall in Nurses' Notes was on 04/09/21. She stated the nurse should write a progress note to enter the SBAR, but it wasn't done. She stated vitals should have been filled in. She verified the box indicating the care plan was reviewed was not checked as well as not documenting immediate actions that were taken. She stated the resident was sent to the hospital and the documentation did not say what would be done to prevent the next fall. She verified there was a lack of description of what happened. In an interview on 04/15/21 at 6:56 PM EI #2, the Director of Nursing (DON) stated RI #54 was sent out right away to the hospital after her fall because it was an emergency. That may have been why vital signs were not taken. She stated the nurses were trained to do SBAR charting. The purpose of SBAR charting was to prevent hospitalization. She stated the staff were to fill out the risk management tool in the computer and address the fall in the morning meeting. She stated when the resident came back from the hospital, she would expect a nurse's note with interventions. She verified no Nurse's Note was written for RI #54 on 04/07/21 or 04/08/21. She stated the 1088 form was the fall risk management form that should be filled out as soon as the resident was safe, indicating when and what happened. She verified the documentation regarding RI #54's fall was incomplete.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Resident Identifier (RI) #4 was admitted to the facility on [DATE] with diagnoses including end stage renal disease with dependence on renal dialysis, unspecified dementia, congestive heart failure, behavioral disturbance, weakness, and encephalopathy per the admission Face Sheet undated in the EMR. Review of the admission Minimum Data Set Assessment (MDS) with an assessment reference date of 01/06/21 revealed RI #4 was not identified as having a serious mental illness. The resident had a Brief Interview for Mental Status Score (BIMS) 14 out of 15 indicating she was unimpaired in cognition. The resident did not exhibit any mood or behavior issues during the observation period. She required limited assistance of two or more staff for most activities of daily living (ADLs). The resident was given antipsychotic medication all seven days of the lookback period. Review of the Physician's Note dated 01/17/21 revealed RI #4 was recently admitted to the hospital due to issues with vascular access for dialysis. She awakened during the night, while in the facility, and her dialysis shunt blew which required hospitalization. The note read, She was felt to have infection of the fistula. She grew MRSA (methicillin Resistant Staph Aureus). Had undiagnosed dementia with behavior issues with hallucination and was started on Seroquel just prior to that admission apparently . She was too weak for home care and admitted to rehab for strengthening . No severe issues with behavior . Lives with the daughter . Patient care highly complex due to multiple comorbidities and baseline debility. Review of the Physician's Note dated 02/01/21 of RI #4 revealed the resident was being seen for follow up to a recent hospitalization. Under Psychiatric, the resident was documented as having an appropriate affect. The note indicated the resident had been admitted to the hospital for altered mental status secondary to missing dialysis. The note read, Patient mental status seems stable on current regimen with no reported uncontrolled or overly aggressive behaviors. A Physician's Note dated 03/01/21 revealed RI #4 was followed after hospitalization for altered mental status after a fall with confusion and hallucinations. The note revealed since the resident's return to the facility, she had no reported changes in behavior and no increased confusion. Under Psychiatric, the resident was documented with an appropriate affect. Review of the Seroquel Medication Changes Since Admission report (undated) for RI #4 revealed the resident was prescribed Seroquel 25 mg on 12/17/20, one tablet by mouth each night at bedtime for end stage renal disease. On 03/16/21 the dose of Seroquel was decreased to 12.5 mg at bedtime for increased anxiety. This was the current order during the survey. Review of the Consultant Pharmacist's Medication Regimen Review for RI #4 dated 01/14/21 revealed, This resident is receiving the antipsychotic agent Seroquel but lacks an allowable diagnosis to support its use. Please clarify this resident's diagnosis. Review of the Consultant Pharmacist's Medication Regimen Review dated 02/12/21 for RI #4 revealed, This resident was admitted on Seroquel. Ensure that target behaviors warranting antipsychotic use are clearly identified in the clinical record. Monitoring for efficacy of this medication will be based on these target behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Behavior Monitoring and Interventions Report for RI #4 revealed this was a documentation tool for the CNAs. CNAs checked the appropriate box for No Behaviors or the corresponding box for specific behaviors exhibited. There were 59 specific behaviors identified that the CNAs could check the box to indicate the behavior occurred on their shift. The Behavior Monitoring and Interventions Report was reviewed from admission on [DATE] through 04/13/21. In each instance, the box for No Behaviors was checked. CNA documentation revealed a complete absence of behaviors. Review of nursing Progress Notes for RI #4 from admission on [DATE] through 04/13/21 revealed the resident exhibited behavior once as follows: 02/22/21 at 5:22 PM, As I was walking down the hall from the unit to carry the cart to the kitchen, I answered the light and resident said she needed to be changed that she had been sitting in poop for three hours and she knew that the girls are feeding but she needed to be changed cause she had been sitting there for three hours and no one had changed her . I assisted her to remove her pants and brief not only had no stool in it was dry of urine as well. I educated resident that there was no stool in her brief and that she could sit and attempt to have a bowel movement on the commode. Review of RI #4's Care Plan dated 01/29/12 revised on 04/13/21 revealed the problem of potential for drug related complications associated with use of psychotropic medications including antipsychotic medication. The goal was for the resident to be free of drug related complications. Interventions included assess for pain, consult pharmacy as needed, monthly pharmacy medication review, observe for side effects and report to the physician, provide medications as ordered, evaluate the effectiveness, psychotropic medication risk/benefit and reduction plan as recommended per pharmacist and MD. Review of the Care Plan initiated on 02/20/21 and revised on 02/22/21 for RI #4 revealed a problem of, I sometimes have behaviors which include making false statements 02/20/21 making false claim of bowel incontinence. The goal was for the behavior to stop with staff intervention. Interventions included: Attempt interventions before behaviors began, help the resident to avoid situations or people that were upsetting to her, make sure she was not in pain or uncomfortable, speak to her unhurriedly and in a calm voice. Attempts were made to interview RI #4 during the survey; however, she was either at dialysis (on 04/12/21 and on 04/14/21) or unavailable due to being tired/sleepy. On 04/13/21 at 9:40 AM the surveyor tried to interview the resident who was lying on her back on the bed. The television was on and as she responded, her eyes closed. The resident's response was delayed; she stated she was tired from dialysis the day before. An attempt was made later that day; however, the resident continued to rest in her room and was not available. During an interview on 04/14/21 at 4:08 PM Employee Identifier (EI) #6, Certified Nurse Assistant (CNA) stated the resident was alert and oriented but was often tired or weak after dialysis. She stated the resident needed some help with activities of daily living when she was tired; however, was generally independent in her room. She stated the resident was normally back on the second shift after dialysis and she brought dinner to the resident in her room and set it up. She stated the resident had no behaviors, no anxiety and no hallucinations that she knew of. In an interview on 04/14/21 at 12:32 PM EI #9, Licensed Practical Nurse (LPN) reviewed RI #4's medical record and stated the resident was prescribed Seroquel 12.5 mg for increased anxiety at bedtime, ordered on 03/16/21. She stated behaviors should be documented by nurses under progress notes. She stated behaviors were not documented on the MAR. She stated she had not seen any behaviors exhibited by the resident. She stated the resident went to dialysis during the day three times a week and got (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	back before supper trays came out. She verified the resident had no mental illness diagnoses; her diagnosis was dementia with behavior disturbance. In an interview on 04/15/21 at 4:42 PM EI# 11 Licensed Practical Nurse (LPN) stated the nurses documented behaviors if there were behaviors. She stated nurses should document behaviors in nursing notes. She stated she had never seen RI #4 exhibit any behaviors and she worked full time on the resident's unit. She stated she had never seen the resident experience hallucinations. She stated the resident had some anxiety but it could be redirected and it mostly was related to dialysis. EI #11 stated the CNAs also documented behavior in their charting. She stated she did not know the resident was prescribed an antipsychotic. In an interview on 04/15/21 at 6:35 PM, EI #2, the Director of Nursing stated she thought RI #4 had hallucinations in the hospital prior to admission and it was documented in the resident's record. She stated the resident had behaviors in the facility of telling staff she was sitting in feces, when she was not. EI #2 stated the resident acted as if she really believed she was soiled and needed to be cleaned. EI #2 stated the facility did not utilize consent forms for the use of antipsychotic medications; there was no documented consent for the Seroquel for the resident. She stated a risk versus benefit was conducted as part of the Pharmacist's review of medications. EI #2 stated there were no established targeted behaviors for use of antipsychotic medications for residents with primary dementia diagnoses. In an interview on 4/14/21 at 12:44 PM EI #9, the Consultant Pharmacist stated she reviewed CNA charting for presence of behaviors and looked at the nurses' notes. She stated she was not aware of specific targeted behaviors staff were supposed to monitor related to Seroquel. EI #9 stated RI #4 had a diagnosis of dementia with behaviors; however, the resident had hallucinations in the hospital exhibited compulsive behaviors in the facility. She stated a dose reduction of Seroquel had been done when it was decreased to 12.5 mg and indicated the resident was now up for re-evaluation of the dose again. During an interview with EI #2 Director of Nursing (DON) on 04/15/21 at 7:00 PM confirmed they did not have a specific policy and procedure for psychotropic medications, identifying, and monitoring of targeted behaviors. She stated her expectation was for nurses to write a behavior note detailing any behavior and CNAs are to document behaviors in POC system. Based on interview, observation, record review and facility policy review the facility failed to identify target behaviors, monitor for the target behaviors for antipsychotic medications, ensure a stop date for an as needed (PRN) anti-anxiety medication and provide indications for use for three of six residents (Residents (RI) #4, RI #41, and RI #131.) This failure had the potential to cause residents to receive psychotropic medications without proper indications for use or monitoring for effectiveness. Findings include: 1. RI #41 was admitted to the facility on [DATE] according to the admission Record located under the Profile tab in the electronic medical record (EMR.) According to the Diagnosis's list located on her admission Record in the Profile tab in the EMR revealed she was admitted with diagnoses including unspecified dementia with behavioral disturbance and hallucinations. Under the Orders tab in the EMR revealed RI #41 was prescribed an antipsychotic medication for (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bipolar or schizophrenia, quetiapine 50 milligrams (mg) twice a day for unspecified dementia with behavioral disturbance. Remeron a medication used to treat insomnia and encourage appetite, 15 mg at bedtime, and alprazolam, an antianxiety medication, with two different doses, the first 0.125 mg twice a day and 0.25 mg at bedtime for unspecified dementia with behavioral disturbance. Review of the Medication Administration Record (MAR) for 04/21 revealed RI #41 received the psychotropic medications as ordered. The MAR did not include any indications for use other than the diagnosis of dementia with behavioral disturbance, with direction for staff to monitor for targeted behaviors. Review of the Progress Notes tab in the EMR revealed there were no notes identified as Behavior Notes. Review of the Point of Care (POC), a system in the EMR where Certified Nurses' Aides (CNAs) documented behaviors, showering or bathing, dressing, eating, toileting, and any assistance provided to the resident. The POC notes failed to show any behaviors exhibited by RI#41. The CNAs consistently marked no behaviors although there were columns for .Physical Behaviors Directed at Others, Verbal Behaviors Directed at Others, Socially Inappropriate Behaviors, Other Behaviors Not Directed at Others, and under each heading there were multiple behaviors such as grabbing others, pushing others, cursing at others, disrobing in public, spitting, agitated hallucinations, hoarding, etc. Review of the POC documentation from 12/13/20 through 04/11/21 revealed the CNAs had not marked any column other than . No Behaviors Observed . The POC failed to have a section that identified targeted behaviors for RI#41 that required monitoring. 2. Review of RI #131's admission Record under the Profile tab the EMR revealed she was admitted on [DATE] after a hospital admission. The Orders tab in the EMR revealed she was on aripiprazole a medication used to treat bipolar and schizophrenia, 10 mg at bedtime for .unspecified dementia without behavioral disturbance . and alprazolam a medication used to treat anxiety, 0.25 mg .every 24 hours as needed for anxiety related to unspecified dementia without behavioral disturbance . Review of the 03/21 and 04/21 she was given the aripiprazole daily and had not required any of the alprazolam. Review of Consultant Pharmacist Interim Medication Regimen Review dated 03/18/21 revealed Employee Identifier (EI) #9 Consultant Pharmacist identified two medications requiring additional information from the physician prescribing them. A statement next to the alprazolam stated, .complete CMS (Centers for Medicare and Medicaid Services) review if PRN anxiolytic (a classification of medications) continued beyond 14 days .Aripiprazole 10 mg . Ensure a CMS compliant diagnosis, identify and monitor target behaviors, and monitor for consequences of antipsychotic uses . The physician response was documented as a telephone order (TO) on the bottom of the page. The TO read, .cont. (continue home medication on short term resident until DC (discharge) from center . An interview with EI #9 was conducted on 04/14/21 at 4:45 PM and she confirmed RI #131 was in the facility for short-term rehabilitation. She stated the physician was consulted by the facility for a response to the Consultant Pharmacist Interim Medication Regimen Review dated 03/18/21 and his response was acceptable to continue the PRN alprazolam and the antipsychotic medication without adequate indications for use. She stated, The facility performs behavior monitoring on residents and the CNAs documented behaviors in POC. During an interview on 04/15/21 at 9:00 AM EI #26, Director of Clinical Care, revealed the facility did not have a policy and procedure specifically for the use of psychotropic medications and the monitoring of targeted behaviors. She stated the CNA's monitored resident behavior in the POC system and nurses charted by exception. During an interview with EI #2 Director of Nursing (DON) on 04/15/21 at 7:00 PM confirmed they did (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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not have a specific policy and procedure for psychotropic medications, identifying, and monitoring of targeted behaviors. She stated her expectation was for nurses to write a behavior note detailing any behavior and CNAs are to document behaviors in POC system. EI #2 provided a copy of the policy and procedure titled, .Medication Monitoring . The policy stated, .The facility employs a system to assure that medication usage is evaluated on an ongoing basis . It also stated, .All psychotropics-monitor behavioral expressions or indications of distress .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2021
NAME OF PROVIDER OR SUPPLIER Diversicare of Arab		STREET ADDRESS, CITY, STATE, ZIP CODE 235 Third Street SE Arab, AL 35016	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview and policy review, the facility failed to store all drugs in locked compartments in one (100 Hallway) of three lockable medication carts. The facility reported 51 residents residing in the 100 and 300 hallways that had potential access to the unlocked medications. Findings include: 1. On 04/12/21 at 9:45 AM an Employee Identifier (EI)#2 Director of Nursing (DON) was escorting the survey team to the conference room when observation of the medication cart parked by the 100-hall nursing station with the unlocked drawers containing medication toward the hallway.The surveyor pointed out to EI#2 the cart was unlocked. EI#24 Licensed Practical Nurse (LPN) was present in the nurses' station with the medication cart unlocked but the unlocked cart was out of her view. EI#2 instructed EI#24 to lock the cart. EI#2 nodded her head in acknowledgement the medication cart was unlocked and out of the view of EI#24. On 04/15/21 at 9:55 AM the 100-hall medication cart was observed to be unattended and unlocked parked by the 100-hall nursing station with the unlocked drawers facing toward the hallway. Resident (Resident (RI)#41 was seated, sleeping in her wheelchair approximately 10 feet away from the unlocked medication cart. The surveyor proceeded to observe the medication cart in its unlocked state for 10 minutes. The EI#24 was not in the area and was the nurse responsible for the medication cart security. EI#2 and Interim Administrator EI#1 were notified the cart was unlocked and unattended for the 10 minutes. EI#24 was instructed to lock the medication cart as required per policy. Interview with Employee Identifier (EI) #9, the Consulting Pharmacist, on 04/14/21 at 9:07 AM confirmed medications are to be secured in the locked medication carts or in the locked medication storage room. Interview with EI#2, Director of Nursing, on 04/14/21 at 2:30 PM confirmed medication carts are to be locked when staff are not present. Review of the facility's policy titled Medication Storage, updated on 06/12, states Policy .The facility is responsible for maintaining proper storage . and Procedure .Medication carts are mobile, locking . and it is the responsibility of the facility to keep the medication carts always locked and secure.

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NAME OF PROVIDER OR SUPPLIER: Diversicare of Arab		STREET ADDRESS, CITY, STATE, ZIP CODE: 235 Third Street SE Arab, AL 35016	

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, record review, and policy review, the facility failed to ensure the menus were followed. Ten residents prescribed pureed diets (Resident Identifiers (RI) #24, RI #75, RI #27, RI #7, RI #46, RI #38, RI #3, RI #25, RI #2, RI #43) were not served pureed bread as directed on the menu during two of two meals observed. In addition, condiments indicated on the menu such as salt, pepper, and margarine were not served to residents on the 300 Hall during two of two meals observed. Three of 22 residents who ate meals on the 300 Hall RI #67, RI#79, RI#56) stated they would like to be served salt, pepper, and/or margarine with their meals. Findings include: 1. The Week 2 Diet Spreadsheet and Week at a Glance Menu (both undated) revealed lunch on Monday (4/12/21) for residents on regular diets consisted of: swiss steak, parly (sic) potatoes, brussel sprouts, vanilla pudding, and dinner roll/margarine. According to the Week at a Glance Menu, residents on pureed diets were to be served: pureed swiss steak with gravy, pureed parly (sic) potatoes, pureed brussel sprouts, vanilla pudding and pureed buttered dinner roll. The first of two food carts arrived on the 300 Unit at 04/12/21 at 12:38 PM. Residents' trays were removed from the food carts that were delivered from the kitchen. Residents were served meals on trays in their rooms. Nursing staff began passing the residents their trays at 12:40 p.m. The surveyor checked all the tray cards and observed each tray as the staff served the residents on the 300 hall their meals. Although there was a plastic container with salt and pepper packets (and creamers and sugars) available on a cart, residents were not served/offered salt and pepper packets with their meals and the meal trays did not include margarine to go with the rolls. Margarine was not available on the cart with the other condiments. On 4/12/21 at approximately 12:45 PM Employee Identifier (EI) #13, Licensed Practical Nurse (LPN), who was assisting with delivering room trays, stated there was no margarine available to be served with the dinner rolls. The rolls were observed to be dry; no margarine had been added in the kitchen. On 4/12/21 at approximately 1:15 PM. EI #12, Certified Nurse Assistant (CNA) was feeding RI #3 his pureed diet and stated the foods on his plate consisted of pureed meat, pureed vegetable and pureed potatoes. On 04/12/21 residents on pureed diets on the 300 Hall included (RI #7, RI #3, RI #2). During meal observations between 12:48 PM and 1:32 PM these residents were served pureed swiss steak, pureed potatoes and pureed brussel sprouts. They were also served pudding and beverages; however, they were not served pureed buttered rolls. Meal observations concluded at 1:32 PM. 2. Pureed diet preparation was observed in the kitchen on 4/14/21 for the lunch meal. At 9:32 AM EI #8, the cook stated she would prepare the pureed items for lunch for the 10 residents on pureed diets. She placed cooked turkey roast into the Robot Couple bowl (commercial food processor) and added chicken broth and thickener, pureeing until the correct consistency was achieved. She stated she still had sweet potatoes, cauliflower and peanut butter cookies to puree but would do that later. At 10:30 AM EI #8 prepared pureed cauliflower in the Robot Coupe which consisted of cooked (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2021

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F 0803

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

cauliflower with no extra liquid or thickener added. After that, she prepared pureed sweet potatoes and milk together in the Robot Coupe and then added thickener to achieve the correct consistency. The last item pureed were the peanut butter cookies. She added milk and thickener and pureed the cookies to the correct consistency. She confirmed all the pureed items for the lunch meal had been prepared.

At 11:32 AM observation of tray line was conducted with EI #8 to measure the food holding temperatures. At this time, the pureed menu items of pureed turkey, pureed sweet potatoes, pureed cauliflower and pureed peanut butter cookies were observed on the tray line. There were no pureed buttered rolls on the tray line. and Week at a Glance Menu (both undated) revealed lunch on Wednesday (4/14/21) for residents on regular diets consisted of roast turkey and gravy, glazed sweet potatoes, buttered cauliflower, peanut butter cookies, dinner and roll/margarine. Residents on pureed diets were to be served pureed roast turkey with gravy, pureed candied sweet potatoes, pureed buttered cauliflower, pureed peanut butter cookie and pureed buttered dinner roll.

On 04/14/21 at 12:35 PM observations on the 200 Unit dining room revealed residents receiving pureed diets (RI #27 and RI #43) were eating their meals. They had been served pureed turkey, pureed sweet potatoes, pureed cauliflower and pureed peanut butter cookies, but no pureed buttered rolls.

On 04/14/21 starting at 12:48 PM observations were made in the 300 Unit. Residents on pureed diets (RI #7, RI #3, RI #2) were served pureed turkey, sweet potatoes, cauliflower and peanut butter cookies, but no pureed buttered rolls.

At approximately 12:52 PM RI #56 was eating her lunch in her room. She stated she was not allowed to have salt but would like to have pepper with her meals but had not been served or offered pepper. There were no condiments such as pepper or margarine observed on her meal tray. The resident's tray card indicated she was on a reduced sodium diet.

On 04/14/21 at 12:53 PM EI #10, CNA was interviewed on the 300 Unit. She stated the staff only served the salt and pepper packets to residents if they asked for them. She said the only resident on the 300 Unit that asked for it was RI #19. She stated margarine did not come on the meal trays from the kitchen and it was not included with the condiments on the cart. She indicated it was not available to be served.

On 04/14/21 at 12:54 PM RI #67 was eating lunch in her room. She stated she was not served salt but would eat better if she had it. She stated, I don't get salt. They don't ever bring it. She stated the staff did not bring margarine for the rolls either. No salt, pepper or margarine were observed on her tray. The resident's tray card was reviewed and indicated she was on a regular diet without any restrictions.

On 04/14/21 at 12:57 PM the cart with condiments in the 300 Hall had salt and pepper packets but no margarine.

On 04/14/21 at 1:08 PM RI #7 was finishing her lunch and stated she liked pepper with her meals. There were no pepper packets or margarine observed on her meal tray. Her tray card indicated she was on a reduced sodium diet.

4. On 04/15/21 at 10:08 AM EI #27, the Dietary Supervisor was interviewed. She stated it was an oversight on the part of the dietary department not providing the pureed buttered rolls. She stated

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015148	A. Building B. Wing	04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Arab	235 Third Street SE Arab, AL 35016

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they had a mix for the pureed rolls and it should have been prepared on 04/12/21 and 04/14/21 for lunch. She stated the dietary staff used to put the salt and pepper packets on residents' trays; however, now the CNAs were supposed to add it when they served the residents. She stated the dietary department would go back to putting salt and pepper on the trays in the kitchen. She verified margarine had not been served with the rolls, indicating the dietary staff forgot. On 04/15/21 at 4:56 PM EI #11, LPN stated dietary was supposed to put the margarine/butter on the trays in the kitchen and nursing staff was supposed to give residents salt and pepper packets. The Therapeutic Diets policy dated 8/1/12 revealed, It is the policy of this facility to provide therapeutic diets when prescribed by the attending physician and to serve these diets as ordered . Prescribed therapeutic menus are planned per written orders for diet prescriptions . A tray identification system is established to ensure that each resident receives his/her diet as ordered.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

Based on observations, interview, record review, and policy review the facility failed to ensure the kitchen was maintained in a sanitary manner creating the risk for foodborne illness to 75 of 78 residents (three residents received nutrition from tube feeding) residing in the facility. Kitchen flooring, surfaces, and areas were not sanitary and were in need of cleaning and repairs.

Findings include:

1.The initial kitchen inspection was conducted with the Employee Identifier (EI) #27, Dietary Supervisor on 04/12/21 from 9:59 AM - 10:20 AM The following concerns were noted during the initial inspection:

a. Can opener -The can opener was observed with a layer of accumulated black residue on the cutting blade.

b. Large stainless-steel shelf - A large stainless-steel shelf attached to the stainless-steel table/counter (located a few inches above the floor) was observed to be completely covered in rust. A shelf liner partially covered the shelf; however, approximately 20% of the shelf was not covered by the liner. Sheet pans were stored in a rack directly on the rusted portion of the shelf. EI #27 stated maintenance staff used to paint the shelf years ago but it had not been painted in a long time. EI #27 verified the rusted surface needed to be addressed.

c. Small stainless-steel shelves - There were two small, rusted shelves (approximately ten inches in length) that were covered with food crumbs and particles. The shelves were attached to the stainless-steel table/counter and were located directly below the countertop. EI #27 stated the shelves used to contain drawers but the drawers were no longer present. Knives and baking paper were stored directly on one of the rusted and soiled shelves and potholders were stored directly on the other rusted and soiled shelf. EI #27 stated the stainless tables with the rusted shelves needed to be cleaned and the rust removed or painted.

d. Tile floor - The brick-colored tiled floor throughout the kitchen had accumulated food residue and particles spread throughout. There were two tiles near most of the surface on top of the tiles was black. The grout (approximately an inch wide in places) on the floor around the floor drain by the dishwasher was uneven. The area in the grout that was lower (around the floor drain) contained accumulated food residue. EI #27 verified it was hard to clean the uneven surface. EI #27 stated the dietary staff cleaned and mopped the tile floor twice a day. There were two tiles near the dish machine that were missing, leaving an area in which food residue and grime accumulated. EI #27 indicated the tiles needed to be replaced. There were two additional tiles in the dish machine area that were broken with pieces of the tiles missing.

e. Floor drains - There were two floor drains that were in a state of disrepair and were significantly soiled. The floor drain located near the stainless-steel counter and storeroom had two chipped corners. The missing corners revealed blackness below. There was no evidence of flooring located beneath the floor drain. This created a potential entry point for pests and insects. This floor drain was discolored; approximately half of the interior surface and edges of the drain was covered with orange and black residue and food particles. The second-floor drain located in the dish machine area was broken along one of the edges. The entire length of the floor drain on one side was broken; The

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2021
NAME OF PROVIDER OR SUPPLIER Diversicare of Arab		STREET ADDRESS, CITY, STATE, ZIP CODE 235 Third Street SE Arab, AL 35016	

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	missing piece was approximately one inch wide and 12 inches long creating an uncleanable surface. EI #27 stated the drains had needed replacement for about six months. f. Rusted metal box - There was a significantly corroded metal box (75% of the box was rusted and had corroded) located on the floor directly underneath the table on which the clean dishware came out of the dish machine. An unused metal pipe, which was not connected to anything per EI #27, went into the box. EI #27 stated the box was not hooked up to anything and it did not serve a purpose. g. Black substance on the wall in the dish machine area - There were multiple lines and sections of black build up/growth along the wall and along baseboard (adjacent to the tile floor) under the counter of the clean side of dish machine. The wall was constructed of large bricks that had been painted white. There were multiple areas of peeling paint with the black growth/residue affixed to these areas as well as along pipes that ran along the wall and all along the base board. The area was approximately four feet in length and two and a half feet high. EI #27 stated she did not know what the black substance was. In addition, there was a section of the wall with significant black build up/growth located right next to the door of the dish machine where the clean items slid out on racks onto the stainless-steel counter. The section of the wall with the residue was approximately six by 12 inches in size and was located next to a stainless-steel back splash to protect the wall from water. h. Steamer - The steamer, located on a stainless-steel counter in a food preparation area, was noted to have a meal tray placed below it that was full to the brim with water. When the steamer door was opened, rust and food particles were observed along the edge where the door sealed when shut. EI #27 stated the steamer leaked and needed a new gasket on the door so it would seal properly of the bottom edge of the door. She stated the tray had to be emptied three times a day to remove the water that leaked from the steamer. 2. A second kitchen observation was conducted with EI #27 on 04/14/21 from 8:43 AM - 8:55 AM with the following concerns noted: a. Can opener - The can opener continued to have the layer of accumulated black residue on the cutting blade. EI #27 confirmed it needed to be cleaned and stated it would be run through the dish machine. She stated it should be cleaned every shift and verified it had not been. b. Large stainless-steel shelf - The rust on the large stainless-steel shelf was noted. However, the shelf liner had been adjusted to cover the area in which the sheet pan rack with pans was located. EI #27 stated the shelf had been cleaned. c. Small stainless-steel shelves - Food crumbs and particles were observed on the two small, rusted shelves. EI #27 stated the shelves should be cleaned. She stated these shelves were not on the cleaning schedule. Potholders and knives were observed on the shelving. d. Tile floor - The two tiles near the dish machine continued to be black on most of the surface on top of the tiles. The uneven grout on the floor around the floor drain continued to contain accumulated food residue/grime. The two tiles near the dish machine continued to be missing with grime accumulated in the space where the tiles were gone. The two additional tiles in the dish machine area that were broken remained in the same condition. EI #27 stated the tiles needed to be replaced and stated she would make sure maintenance knew about all four tiles in dish machine area. She also stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

it was hard to remove the grime/soiled areas from the tiles.

e. Floor drains - The two floor drains were in the same state of disrepair with chipped edges and missing sections. They continued to be soiled with food, and orange and black residue. EI #27 verified the presence of the black and orange substance and stated she was not sure what it was.

f. Black substance on the wall in the dish machine area - The wall and baseboard in the dish machine area continued to have multiple lines and sections of black build up/growth under the counter of the clean side of dish machine. EI #27 stated the staff scraped some of it off and they would keep working on it. She stated it was difficult to access the area of the wall under the counter in the dish machine area. She stated it was not on a regular cleaning schedule.

h. Steamer - The steamer continued to have a meal tray placed below it on the table that was approximately half full of water. When the steamer door was opened, rust and food particles were observed along the edge where the door sealed when shut. EI #27 stated the EI #15, the Maintenance Supervisor was aware and would order a new gasket.

The CMD stated, during the second kitchen observation, the issues identified during the initial inspection on 04/12/21 had been reported to the maintenance department. EI #27 stated the facility used a computerized system to report maintenance concerns. EI #27 stated she had reported concerns to maintenance on an ongoing basis but could not access any records to demonstrate this. She stated the maintenance department might have records of what had been reported previously. When asked if there was a cleaning schedule, EI #27 stated the dietary department had written guidelines for cleaning which she would provide. She stated there were daily cleaning assignments; however, staff did not sign off to indicate the cleaning had been done.

3. Interview with EI #15 was conducted on 04/14/21 at 10:45 AM who stated maintenance concerns were put into the computerized work order system by staff such as EI #27. He stated he had been employed by the facility for about a year. He stated he checked for new work orders first thing every morning. He stated he repaired things as needed and had scheduled maintenance as well such as cleaning the coils in the freezer and changing out filters. When asked about when he was notified of the steamer leaking, he stated he was informed on Monday (04/12/21). He stated it needed a new gasket and he was in the process of looking for the right one. When asked about the condition of the floor drains, he stated he had been notified on 04/12/21 and EI #1 was trying to find the right ones so they could be replaced. He stated he also became aware of the floor tiles that needed to be replaced on 04/12/21.

4. A kitchen inspection of the areas in need of repair was conducted on 04/14/21 at 11:01 AM with the EI #15. The wall in the dish machine area with the black residue/growth was observed. EI #15 stated he did not know what the substance was. He stated he had not been notified of this concern. He scraped an area of the residue and said it was greasy. He stated there were sections of peeling paint where the black substance accumulated and it could be food. He stated the area needed to be cleaned and the black substance needed to be removed. He stated there was a lot of moisture in this area and he would get together with EI #1 and determine how to address it.

In a subsequent interview on 03/14/21 at 11:39 AM, EI #15 stated at 2:30 PM after the kitchen closed for lunch, he would clean, dry and repaint the wall where the paint was coming off and black substance was located. He also said he would caulk along the stainless-steel back splash so water would not get behind the area and onto the wall.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. A policy for maintenance/maintenance work orders was requested. On 04/14/21 at 5:55 PM EI #1 stated there was no policy for building maintenance/work orders. 6. Review of the Work Order report dated 04/14/21 for the previous 12-month period revealed none of the issues identified in the kitchen had been reported or entered the maintenance work order system. The Sanitation policy dated 08/01/12 revealed it was the policy of the facility to maintain equipment, work surfaces, walls and floors in sanitary condition through daily, ongoing procedures. The procedure included: Cleaning schedules are established to assign specific tasks to scheduled employees on a daily, weekly and monthly basis . Formal sanitation inspection in the food service department occurs on a frequent basis. Informal sanitation inspections occur daily.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Provide and implement an infection prevention and control program.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 4. Resident Identifier (RI) #3 was admitted to the facility on [DATE]; diagnoses included in pertinent part: cerebrovascular accident (CVA), altered mental status, muscle weakness, acute kidney failure, urine retention, and obstructive and reflux uropathy (04/14/21 Face Sheet).

Review of the Physician Order Summary Repor dated 04/14/21 revealed the resident had a suprapubic catheter. Following discontinuance of a Foley catheter, a suprapubic catheter was inserted on 03/28/21 related to obstructive and reflux uropathy, retention of urine. Catheter care was to be completed every shift. The catheter was to be replaced when needed due to dislodgement or occlusion.

Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE], the resident had a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment (score of 0 - 7 indicative of severe impairment). The resident was totally dependent on two or more staff for most activities of daily living (ADLS) such as bed mobility, transfers, locomotion on and off the unit, and toilet use. The resident utilized a catheter (indwelling at the time). The resident was identified as having a UTI within the past 30 days.

Review of the Physician's Progress Note dated 02/01/21 revealed the resident was readmitted to the facility on [DATE] for a UTI with urinary retention with obstructed Foley catheter with blood clot. The note indicated the resident also had a UTI in 06/2020.

Review of the Care Plan dated 11/29/20 revealed the problem of alteration in elimination of bowel and bladder. The resident had urinary retention with a catheter in place. The goal was for the resident to be free of urinary tract infections (UTI). Interventions included monitoring urine output, anchoring the catheter, avoiding excessive tugging, catheter care every shift and as needed, and observe and report signs and symptoms of UTIs.

During an interview on 04/13/21 at 10:02 AM the resident's family member stated the resident had a history of UTIs and had previously pulled out his catheter.

Observations during the survey revealed the resident's catheter bag was observed to have been placed in a manner that it rested directly on the floor as follows:

On 04/12/21 the resident was observed lying in bed with the catheter bag resting directly on the floor at 9:58 AM, 10:20 AM, 11:05 AM., 1:25 PM (while he was being fed lunch by staff in bed), 2:40 PM and at 5:50 PM.

On 04/13/21 the resident was observed lying in bed with the catheter bag resting directly on the floor at 8:32 AM. (while he was being fed breakfast by staff in bed) and at 9:27 AM.

On 04/13/21 at 11:08 AM and at 2:50 PM the resident was sitting in his wheelchair in the hallway right outside the door to his room. The catheter bag was resting on the floor.

On 04/14/21 at 8:44 and at 11:54 AM the resident was lying in bed. The catheter bag was resting on the floor.

On 04/14/21 at 11:54 AM EI #2, the DON accompanied the surveyor to the resident's room. She

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	verified the catheter bag was resting on the floor. She stated it could hang higher, but it was not hooked on anything. She stated, this bed doesn't have the hook. We will work on that. It is a closed system so it shouldn't be a problem being on the floor. She then stated the catheter should be placed so it would not rest directly on the floor. In an interview on 04/14/21 at 4:13 PM EI # 6, Certified Nurse Assistant (CNA) stated the resident required total care of two staff. The resident was unable to participate in care and he didn't talk except for a few words here and there. She stated the resident was confused. She stated staff were supposed to hook the catheter bag on the bed frame in a privacy bag and it should be hanging above the floor. She stated the catheter bag was also hooked on the wheelchair so it would hang above the floor when he was up in the chair. She stated the resident had some bleeding with the catheter, reporting it was an ongoing issue. In an interview on 04/15/21 at 4:39 PM EI #11 Licensed Practical Nurse (LPN) stated a resident's catheter bag should never touch the floor. She stated there was a place to hang it so it would be located above the floor. She stated RI #3's bed was in a low position at times, but the bag could be hung so it did not rest on the floor. She stated having the bag rest on the floor was an infection control issue. In an interview on 04/15/21 at 6:29 PM EI #2, the DON stated they used [NAME] and [NAME] as a reference for catheters. They did not have a policy that addressed whether a catheter could be sitting on the floor. She stated the document she gave the surveyor regarding inserting catheters did not address whether a catheter could be on the floor. She stated it was a closed system and the bag being on the floor was not an infection control concern. However, she stated she had not been trained as a nurse to put the catheter bag on the floor. The facility provided copies from a book titled, Clinical Nursing Skills & Techniques, 9th Edition, 2018, Chapter 34 Urinary Elimination, when a request for a catheter policy was made. On 04/15/21 at 5:00 PM EI #1, the Administrator said all policies had been provided. The pages from this book did not address catheter bag location, such as whether it was acceptable for the bag to be resting on the floor. Review of the website for the Association for Professionals in Infection Control and Epidemiology (APIC) website, https://apic.org/Resource_/TinyMceFileManager/Topic-specific/APIC_Infographic_-_LTC_-_FINAL-02.jpg The Power of 10. Your Role in Preventing Catheter Associated Urinary Tract Infections in Nursing Homes, directed nursing home staff to, Keep the urine collection bag below the bladder and off the floor. 3. The facility Memory Care Unit, (MCU is designed to provide care for a resident with an issue with cognition), had a census of 25 current residents. Review of the facility records of resident's immunization status revealed all residents on the MCU have been fully vaccinated for COVID-19. This would include Resident Identifier (RI) #61, RI #80, RI #27, RI #10, RI #57, RI #58, RI #64, RI #68, RI #43, RI #65, RI #26, RI #30, RI #8, RI #6, RI #15, RI#69, RI#22 and RI #26. These 18 residents are residents who frequent the living areas of the unit. Observation of the MCU on 04/12/21 at 12:00 PM revealed 11 residents seated at four tables in the living room with two to three residents per square table. Eight residents were seated at four square tables in the dining room with one to three residents per table. Three residents were seated at 2 long tables with the residents one resident directly across from another resident. No residents were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2021
NAME OF PROVIDER OR SUPPLIER: Diversicare of Arab		STREET ADDRESS, CITY, STATE, ZIP CODE: 235 Third Street SE Arab, AL 35016	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wearing mask. Spacing between residents was observed to be about four feet apart overall. Observation of residents in the MCU on 04/12/21 at 12:21 PM revealed the 18 residents in the living room, dining room or music room were not wearing a mask. Residents were prepared and waiting for lunch to arrive on the unit. Residents were listening to music and conversing with each other and staff. Staff present in the room were Employee Identified (ID) #5, Licensed Practical Nurse (LPN). Observation of residents in the MCU on 04/12/21 at 4:05 PM revealed 17 residents in the living room, dining room or music room were not wearing a mask. Resident were seated less than 4 feet from each other, watching TV and conversing with each other. Facility staff present in the room was EI #5. Observation of residents in the MCU on 04/13/21 at 8:35AM revealed the 18 residents in the living room, dining room or music room. Resident were seated less than 4 feet from each other, conversing with each other and eating breakfast. Staff present in the room including EI #5. Interview with Employee Identifier (EI) #5 Licensed Practical Nurse (LPN) and EI #14 LPN on 04/14/21 at 10:30 AM revealed when the building had COVID 19 positive residents the residents were encouraged and assisted to wear face masks. EI #5 and EI #14 confirmed Resident Identifier (RI) #61, RI #80, RI #27, RI #10, RI #57, RI #58, RI #64, RI #68, RI #43, RI #65, RI #26, RI #30, RI #8, RI #6, RI #15, RI#69, RI#22 and RI #26 were no longer encouraged and assisted by facility staff to wear face masks when out of their rooms because they were all fully vaccinated. Interview with EI #2, Director of Nursing, on 04/14/21 at 2:30 PM confirmed EI #2, Director of Nursing, stated, since residents on MCU had been vaccinated, the residents were no longer encouraged and assisted to wear face masks. Based on observations, interviews, record review, policy review, and Center for Disease Control (CDC) guidance the facility failed to ensure infection control practices were implemented to prevent the potential spread of infection. The facility failed to enforce the practice that required staff and residents to wear a mask appropriately to cover the nose and mouth when in close contact with others and in general population areas of the facility. Resident Identifier (RI) #41, RI #5, RI #70, and RI #66 failed to follow guidance to wear a mask to cover both mouth and nose when out of their room. Eighteen of 25 Residents who resided on the secure unit ate meals in a dining room without maintaining social distance and staff failed to direct residents to wear a mask per guidance. All residents on the secure unit received the vaccine to protect them from the Coronavirus. The facility failed to maintain a catheter in a sanitary manner for one of two residents (RI #3) reviewed for catheter care. Failure to follow infection control practices put all residents and staff at risk to develop an infection. The current census is 78 and the county positivity rate is 4.1%, with no current COVID positive resident in house and 4 resident on the quarantine unit. Findings include: Review of QSO-20-39 NH Revised 03/10/2021 listed on page 2 the Core Principles of COVID-19 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Infection Prevention .Face covering or mask (covering mouth and nose) .Social Distancing at least six feet between persons .These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes and should be adhered to at all times While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). Facilities should consider additional limitations based on status of COVID-19 infections in the facility. Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering (except while eating). Facilities may be able to offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. 1. On 04/12/21 at 9:35 AM the surveyors arrived at the facility on the first day of the survey and were screened at the main entrance door. The main entrance consisted of a hallway accessing the rest of the building. It was part of resident accessible space within the building. EI #12, Certified Nursing Assistant (CNA) conducted the screening. She pulled her mask down below her nose to talk to the surveyors and asked them the screening questions with her mask below her nose. When she was finished talking and screening the surveyors several minutes later, she pulled the mask back up covering her nose. This was observed by all three surveyors. On 04/12/21 at 12:37 PM resident (Resident Identifier (RI) #41 was observed in her wheelchair self-propelling on the 100-hall unit. RI #41 was observed not wearing a mask while two staff interacted with the resident. Employee Identifier (EI) #24 Licensed Practical Nurse (LPN) and EI #7 Activities Supervisor were observed talking to RI #41 however they did not encourage her to put on a mask or redirect the resident to do so. At 12:45 PM on 04/12/21 RI #5 was observed ambulating independently in the hall with a mask worn below her nose and covering her mouth; the mask had a brownish red stain on the top edge of the mask. EI #7 spoke with the resident but did not offer a new mask or provide redirection to pull her mask up over her nose. On 04/12/21 at 4:30 PM RI #70 was observed up in her wheelchair with EI #18 Certified Nurses' Aide (CNA) escorting her to the shower room. EI #18 was wearing a procedure mask while the resident was not wearing one. EI #18 did not encourage or redirect the resident to wear a mask. EI #18 was interviewed at that time and confirmed the resident was not wearing a mask and she had provided no instruction or direction to wear a mask. 2. On 04/14/21 at 5:17 PM observation revealed a resident was escorted into the facility by two ambulance attendants. RI #66 was observed to be lying on the stretcher on his back and was not wearing a mask. He was met at the front door by EI #26 the Director of Clinical Care. EI 26 and the two attendants were observed wearing masks. No other staff or residents were in the vicinity. RI #66 was escorted immediately to a room on the quarantine hall. Interview of EI #26 on 04/14/21 at 5:25 PM verified RI #66 was transported down the hall without a mask in place. EI#26 verified RI#66 should have had a mask on when being transported down the hallway to the Quarantine Unit due to unknown status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview of the Interim Administrator EI #1 on 04/15/21 at 5:00 PM the Infection Preventionist reviews the staff log and the visitor/vendor log to confirm screening is completed. EI#1 was asked for a policy related to residents wearing masks when out of their rooms stated, We don't have one. Diversicare got rid of most of our policies and procedures a few years ago. When asked about COVID-19 related policies and procedures she stated, We have the Guide Diversicare created and we train staff to it .It was updated frequently during the pandemic and reissued . numerous times. Review of the Diversicare COVID-19 Education, Prevention & Response Guide last updated on 03/15/21 stated, .Recognizing that some residents can't or won't wear facemask, if at all possible: Residents should wear a mask when out of their room . In an interview with EI #2 on 04/15/21 at 7:09 PM, EI #2 was asked about staff not wearing masks covering their noses. She stated masks should cover the mouth and nose. However, if a staff member in their office alone or in a staff area with other staff, they could remove their masks if they were socially distanced, six feet apart.