STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015159	A. Building B. Wing	07/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Oneonta	215 Valley Road Oneonta, AL 35121

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on record reviews, interviews, facility document review, the Confirmation of Receipt of Online Incident Report, and facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, the facility failed to ensure staff implemented the facility's abuse policies and procedures when: staff failed to identify an allegation of abuse, protect residents from further potential abuse, and immediately report an allegation of resident-to-resident sexual abuse on 01/14/2023 involving Resident #21 and Resident #2. Multiple staff (Registered Nurse (RN)#4, Certified Nursing Assistant (CNA) #2, Licensed Practical Nurse (LPN) #3, and CNA #37) became aware of the allegation, but no staff reported the incident to the Administrator for two days following the incident, during which time Resident #21 and Resident #2 continued to be roommates, with no measures implemented to prevent further potential abuse. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 (Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of J. The IJ began on 01/14/2023 around 12:35 AM, when CNA #2 observed Resident #2 partially lying on Resident #21's bed. Resident #2 was wearing an unbuttoned shirt and no clothing or undergarments. Resident #2 was unfastening Resident #21's brief. CNA #2 observed Resident #2's upper body close to Resident #21's private area, Resident #2's hand at Resident #21's perineal area and thought Resident #2 was trying to penetrate Resident #21's private area. CNA #2 stated what she observed was sexual abuse; however, she did not take immediate action to protect residents from further potential abuse. CNA #2 reported the incident to LPN #3 who responded and observed Resident #2 sitting unclothed on Resident #21's bed. LPN #3 instructed Resident #2 to get back into his/her bed and did not take any further actions. The residents remained roommates without protective measures to prevent further abuse until 01/16/2023 when the incident was initially reported to the Administrator. This deficient practice placed Resident #2, one of two residents sampled for abuse, in immediate jeopardy, as it was likely to result in serious injury, serious harm, serious impairment or death. On 07/22/2023 at 8:10 AM the Interim Administrator and Director of Nursing (DON) were provided a copy of the immediate jeopardy templates and notified of the findings of substandard quality of care at the immediate jeopardy level in the area of Freedom from Abuse, Neglect, and Exploitation, at F607-Develop/Implement Abuse/Neglect, etc. Policies. The immediate jeopardy began on 01/14/2023 and continued until 01/20/2023, when the facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, immediate jeopardy past noncompliance was cited. Findings included: (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 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility Abuse, Neglect, Misappropriation, Exploitation Policy, effective January 2019, revealed Purpose: To prohibit and prevent abuse . and to ensure reporting and investigation of alleged violations . Definitions: . Alleged Violation: A situation or occurrence that is observed or reported by team member . but has not yet been investigated . The following protocol has been established in the event of an allegation of abuse: 1. Protection First and foremost the resident/patient will be immediately assessed and removed from any potential harm. Examine the resident . for any sign of injury, including a physical assessment or psychosocial assessment . If the suspected perpetrator is another resident/patient, the Administrator/Director of Nursing or designee shall separate the resident/patients so they do not have access to each other until the circumstances of the alleged incident can be determined and assessment completed and if applicable interventions put into place . 4. Prevention. Establish a safe environment: Team members are required to report incidents of suspected abuse, neglect, or misappropriation of property without fear of reprisal . 5. Identification If actual violation or alleged violation occurs the resident will be immediately assessed and removed from any potential harm . 7. Reporting/Response Alleged violations/violations will be reported to the Administrator, designee immediately . A review of Resident #21's admission Record revealed the facility readmitted Resident #21 on 02/28/2019 diagnoses that included Adjustment Disorder with Depressed Mood, Alzheimer's Disease, and Dementia. A review of Resident #21's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/03/2023, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 4 (four) of 15, indicating the resident had severe cognitive impairment. The MDS also indicated Resident #21 required two-person assist for bed mobility and transfers. A review of Resident #2's admission Record revealed the facility readmitted the resident on 04/20/2020 with diagnoses that included Major Depressive Disorder and Insomnia. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #2's annual MDS, with an ARD of 08/05/2022, revealed Resident #2 had a BIMS score of 12 or 15, indicating the resident had moderate cognitive impairment. On 01/18/2023 Resident #2's BIMS was assessed to as 8 (eight) of 15 indicating a decline in cognitive ability since the previous assessment. A review of the Confirmation of Receipt of Online Incident Report from the Alabama Department of Public Health Online Incident Reporting System, revealed the facility notified the state survey agency of a sexual abuse allegation on 01/16/2023 at 12:08 PM. The report indicated on 01/14/2023 at 12:35 AM, Resident #2 was found straddling Resident #21 in their room, with Resident #2's shirt undone and Resident #21's brief undone. Per the report, the Administrator was made aware of the incident on 01/16/2023 at 10:30 AM by Certified Nursing Assistant (CNA) #1. During an interview on 07/18/2023 at 10:49 AM, LPN #32 reported that Resident #2 and Resident #21's beds were position parallel and about one and a half feet apart. LPN #32 added that it was just enough space between the beds where he could fit sideways. During a telephone interview on 07/13/2023 at 11:42 AM, CNA #2 stated she recalled the incident involving Resident #2 and Resident #21 but could not recall the exact time. CNA #2 stated she entered the residents' room to provide care to Resident #21 during her rounds, which she usually conducted around 12:30 AM, 2:00 AM, and 4:00 AM. CNA #2 stated she saw Resident #2 in the bed with Resident #21. According to CNA #2, Resident #2 was wearing only an unbuttoned shirt and was not wearing any bottoms, brief, or underwear. CNA #2 described that Resident #2's feet were in his/her bed, and Resident #2's chest was on the lower part of Resident #21's bed. Per CNA #2 when she entered the room, Resident #2's upper body was close to Resident #21's perineal area and Resident #2 was unfastening Resident #21's brief. CNA #2 indicated Resident #2 had his/her hand positioned at Resident #21's perineal and she thought Resident #2 was trying to penetrate Resident #21's private area. CNA #2 stated she left the room to notify LPN #3, the nurse on duty. CNA #2 reported that she found LPN #3 and reported to LPN #3 that she had a problem and did not know how to fix the situation. CNA #2 continued to tell LPN #3 that Resident #21 was in his/her bed with brief unfastened and Resident #2 was wearing an unbuttoned shirt and near Resident #21's perineal area. CNA #2 said the nurse went to the resident's room and she waited outside the room. CNA #2 reported she knew she should not have left the room, because there was sexual behavior going on and she should have yelled for help instead. CNA #2 stated she told the Administrator she knew she had done wrong, but her first instinct was to get the nurse because the situation was resident abuse. CNA #2 said had she known LPN #3 did not report the incident that she would have reported it herself. CNA #2 said what she witnessed was resident to resident sexual abuse and added she had always considered it to be sexual abuse. On 07/19/2023 during a follow-up interview, CNA #2 said she made the observation of Resident #2 in Resident #21's bed during her first round of the shift, after midnight. During a telephone interview on 06/29/2023 at 10:55 AM, LPN #3 stated she could not remember the date the incident occurred, but CNA #2 notified her that Resident #2 was sitting on Resident #21's bed, naked. LPN #3 stated she walked into Resident #21's and Resident #2's room and observed Resident #2 sitting, without clothes, on Resident #21's bed. LPN #3 stated she told Resident #2 to get back in his/her own bed and the resident did so. LPN #3 stated she did not report the incident to anyone. LPN #3 stated she did not separate the residents because Resident #2 put their clothes back on and got back in their own bed. LPN #3 stated she did not ask Resident #2 why they did not have any clothes on and just advised the resident that it was inappropriate. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 06/29/23 at 9:21 AM, RN #4 reported RN #27 told her about the incident on 01/15/2023. RN #4 said she did not report what she was told because it was over 48 hours after the incident and when she had walked on East wing it was the talk of the town. RN #4 said she thought it had been reported. During a telephone interview on 07/18/23 at 12:35 PM, CNA #37 reported that CNA #2 told her at the end of shift that Resident #2 crawled in bed with Resident #21. CNA #37 said she and CNA #2 talked about the incident that morning and the next night. CNA #37 added that everyone was talking about it. CNA #37 said she did not report the incident because she did not work on the unit in which the incident occurred. CNA #37 added, it was already being talked about all over the building, so she thought that it had been reported. During an interview on 06/29/2023 at 8:50 AM, CNA #1 stated she was the manager on duty the weekend of the incident and heard two nurses and a CNA talk about something that had occurred two days prior. CNA #1 could not recall the names of the nurses. CNA #1 stated the staff said a few days prior another CNA caught Resident #2 on top of Resident #21. According to CNA #1, the nurse told Resident #2 they were not supposed to be doing that, and Resident #2 got down off the bed. CNA #1 stated she heard the incident occurred Saturday (01/14/2023) or Sunday (01/15/2023), and she reported the incident to the Administrator on Monday (01/16/2023). During an interview on 06/30/2023 at 2:23 PM, the Administrator stated the incident occurred Friday night going into Saturday morning 01/14/2023, but she was not made aware of the allegation until 01/16/2023. According to the Administrator, CNA #1 reported to her that she overheard Resident #2 was on Resident #21 with no pants on and Resident #21's brief was not fastened. The Administrator stated staff should report it to her as soon as they see it, even if the staff did not witness the allegation because the staff may not know if the allegation had been reported. The Administrator stated through her interviews, she learned CNA #2 reported the incident to LPN #3, and by the time LPN #3 arrived at the residents' room, Resident #2 was on the side of Resident #21's bed. The Administrator stated staff should know how to protect the residents if they saw anything inappropriate. The Administrator stated CNA #2 was terminated because she should not have left Resident #21 and should have called for another CNA's assistance. According to the Administrator, LPN #3 was terminated because she failed to report the incident and she should have called the Administrator immediately. A review a Progressive Discipline Form, signed by CNA #2, their supervisor, and a witness indicated on 01/20/2023, the facility terminated the employment of CNA #2 for failure to report an instance of sexual abuse on the night of 01/13/2023 to the Administrator. A review a Progressive Discipline Form, signed by LPN #3, their supervisor, and a witness indicated on 01/20/2023, the facility terminated the employment of LPN #3 for failure to report an instance of sexual abuse on the night of 01/13/2023 to the Administrator. During a follow-up interview on 07/18/2023 at 2:21 PM, the Administrator stated CNA #2 told her that she was completing her rounds, and when she got to Resident #21's and Resident #2's room, she found Resident #2 on top of Resident #21's bed and Resident #21's shirt was undone. The Administrator stated it was determined CNA #2 left the residents' room to report the incident to LPN #3, which was a failure to protect the resident. When asked what interventions were implemented from the time the allegation occurred to the time the Administrator was notified, the Administrator stated, Absolutely nothing because the abuse coordinator was not notified. The Administrator stated at the time of the allegation, the residents should have been immediately separated and body assessments should have (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	been completed, as well as notifications to the medical doctor, family, abuse coordinator, police, and state survey agency. The Administrator stated Resident #2 could have been sent out of the facility for an evaluation. The Administrator stated staff should have ensured all residents were protected by providing one-on-one supervision of Resident #2 until the resident could be sent out of the facility for an evaluation. This deficient practice was cited as a result of complaint/report #AL00043048. ********** Once the facility became aware of the allegation of abuse, the facility took the following corrective actions to correct the identified deficient practice: - Resident #21 was assessed for any injury by the Assistant Director of Nursing (ADON) on 01/16/2023, with no negative findings. - On 01/16/2023, Resident #21's room was changed, so that Resident #21 and Resident #2 no longer shared a room. - On 01/16/2023, statements were obtained from facility staff, and CNA #2 and LPN #3 were placed on administrative leave pending the outcome of the investigation. - On 01/18/2023, a behavioral health provider met with Resident #2 and Resident #21 to determine any signs and symptoms of distress related to the incident. - Mandatory in-service on the facility's abuse policy, with an emphasis on reporting and preventing abuse, was conducted with all facility staff from 01/16/2023 to 01/20/2023. No staff were allowed to work until the in-service was completed. - On 01/20/2023, the facility terminated CNA #2's and LPN #3's employment with the facility due to their failure to report an allegation of abuse to the Administrator. -On 01/20/2023 staff abuse in-service completed. -As part of the established quality assurance (QA) committee's practices, abuse investigations continued to be reviewed during the facility's routine QA meetings. ********** After review of documentation supporting the above corrective actions, including the facility's investigation file, in-service/education records, QA documentation, employee disciplinary forms, behavioral health visit notes, and staff interviews, the survey team verified the facility implemented corrective actions through 01/20/2023; thus, immediate jeopardy past non-compliance was cited.