| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 015132 | A. Building<br>B. Wing | 04/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Diversicare of Oxford | 1130 South Hale Street<br>Oxford, AL 36203 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of Facility Reported Incidents (FRIs), review of the facility's investigative file and review of a facility policy titled, Elopement, the facility failed to ensure Resident Identifiers (RI) #119, RI #88, RI #127, and RI #106 received supervision in a manner to ensure their whereabouts were known to the facility and the residents were in an environment free of accident hazards, failed to ensure its Wander Guard system alerted staff when RI #119 exited the facility, and failed to ensure RI #106 was supervised in a manner to prevent elopement after becoming agitated and stating he/she wanted to leave.The facility further failed to implement and follow fall precautions interventions for RI #60 a resident identified at risk for falls. Specifically: 1) On 01/26/2024 at 4:30 PM, (RI) #119 a resident with short term memory impairment was walking unsupervised on the side of a busy, high traffic intersection. RI #119 had a history of wandering behavior and was wearing a wander guard. RI #119 exited the facility around 4:30 PM, but the Wander Guard system did not alert the staff that RI #119 was attempting to leave the facility. RI #119 was located sitting on the ground by the local police department at 8:00 PM in a ditch headed toward the on ramp of I-20 [NAME] bound interstate. It was determined that RI #119 was out of the facility approximately 3 hours and 20 minutes. The facility's investigation did not determine how RI #119 exited the facility. 2) On 04/20/2025 at 7:00 PM, RI #88 was outside in the courtyard with the smoking group of around 16 residents which was being supervised by a single staff member. During that time RI #88 wheeled away from the group down a sidewalk and into the back parking lot. After the group returned inside, RI #88's absence was not identified by the facility's staff. At 7:47 PM someone reported seeing RI #88 outside the facility and down the driveway. RI #88 was located at a store next to the facility at 9:30 PM.3) On 08/22/2025 at 8:50 AM, RI #127 was transported to the front porch by the Director of Nursing. At 9:20 AM, RI #127 was seen outside at the facility near Highway 21 by a CNA (Certified Nursing Assistant) who had received a telephone call from a family member who asked if a resident was missing. The CNA left the building and observed RI #127 at the beginning of Highway 21 on the shoulder of the road in a wheelchair. The CNA ran back to the facility and left RI #127 at the side of the road by him/herself. The CNA alerted other facility staff who responded and assisted RI #127 back to the facility. RI #127 had previously voiced to staff his/her desire to leave the facility and go home.4) On 09/26/2025 around 1:00 PM, RI #106 was noted to be at the front door and having increased agitation. The Director of Nurses Services (DNS) and Social Worker (SW) were present and re-directed RI #106 to his/her room. Around 15 minutes later, RI #106 returned to the front door, remained agitated, and voiced that he/she wanted to leave the facility. RI #106 was last observed sitting outside the facility in his/her wheelchair at 1:50 PM. AT 2:02 PM, the resident was unable to be located by staff. At 2:15 PM RI #106 was located at a restaurant by two CNA's who assisted the resident back into the facility. The facility's investigation determined that RI #106 was assisted out the front door by another resident.It was determined the facility's noncompliance with one or more requirement of participation had caused or was likely to cause, serious injury, harm, impairment or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.25 Quality of Care.On<br>(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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 03/31/2026 at 4:30 PM, the Administrator, and the Directors of Clinical Operations were provided a copy of the Immediate Jeopardy (IJ) template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Quality of Care at F689- Free From Accident Hazards/Supervision/Devices.The IJ began on 01/26/2024 and continued until 04/02/2026 when the survey team verified that onsite corrective actions had been implemented. The immediate jeopardy was removed on 04/02/2026.5) On 03/05/2026 RI # 60 was reported to have fallen and no incident reports were written. The facility further failed to update RI #60's care plans in a timely manner, after previous documented falls and changes in RI #60's condition.These deficient practices affected four of five residents sampled for accidents/elopement, and one of two residents sampled for falls.Theses deficient practices were cited as a result of the investigations of incident/complaint/report numbers 2629802, 2603429, 447964, 447995, and 2800273.<br><br>Findings include:<br><br>A review of a facility policy titled, Elopement, dated 04/2017 documented:<br><br>Purpose<br><br>To establish a process that identifies risk and establishes interventions to mitigate the occurrence of elopements<br><br>Process<br><br>On admission<br><br>Newly admitted or readmitted residents are assessed for elopement risk<br><br>If an elopement risk is determined an individualized plan is established and intervention is initiated to mitigate that risk.<br><br>When the nurse identifies the intervention, it is documented on the care plan and on the caregiver guide.<br><br>A photograph of the resident is taken to assist with identification if necessary<br><br>There is a central system,( i.e. nurse's station, reception area) where information including a photograph regarding all those identified at risk is located.<br><br>After admission when a newly identified risk is identified<br><br>The risk of elopement evaluation is completed to determine interventions<br><br>An individualized plan is established and implemented to mitigate that risk<br><br>The plan is documented on the care plan and caregiver's guide<br><br>Resident representative notification of risk and plan is completed.<br><br>A photograph is taken to assist with identification if necessary<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | If a bracelet alarm is chosen as an intervention there is a plan for monitoring of placement/function<br><br>Door Alarm Protocol<br><br>Team members know how to respond to all door/exit alarms.<br><br>Once Doors/exit alarms are activated a resident search is completed ensuring there is no missing resident.<br><br>When an elopement occurs<br><br>All team members will be alerted to search in the center or grounds as soon as there is an awareness of the resident missing<br><br>If the resident is not quickly located in center or on grounds a point person is designated to make the following notifications:<br><br>Administrator and Director of Nursing<br><br>Designated guardian or resident representative<br><br>Police (once the search of center and grounds determines the resident is not there or sooner if there is good indication they will not be located during the search)<br><br>To assist with identifying the resident: Provide a photograph<br><br>Describe clothes last worn<br><br>When and where resident was last seen<br><br>If resident has an usual route or place they are seeking<br><br>After the resident has been found complete a thorough evaluation of resident's physical condition and psychosocial well beibng. Provide medical intervention as needed.<br><br>Notify resident representative and physician of return<br><br>Establish cause of elopement and address with appropriate plan to prevent reoccurrence.<br><br>Document condition notification and times of actions deployed.<br><br>Review all other residents identified at risk of elopement to ensure current interventions are in place to prevent elopement.<br><br>Quality Assurance<br><br>Patterns or trends in elopements or elopement risks will be reviewed by the QAPI committee.<br><br>1) On 01/26/2024 at 9:18 PM the State Agency (SA) received a FRI alleging that RI #119 eloped from<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | the facility. RI #119 was observed with wandering behaviors daily throughout the facility. A Code [NAME] was immediately called and all the center staff started searching the facility and grounds. The authorities were notified and a wider search was implemented. Resident had a wander guard in place when he/she was found.<br><br>RI #119 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses to include Cognitive Communication Deficit and Dementia in Other Diseases.<br><br>RI #119's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/20/2023 documented a Brief Interview for Mental Status (BIMS) score of 9 of 15, which indicated that RI #119 had short term memory impairment.<br><br>A review of RI #119's care plan titled, Care Plan Report revealed the following:<br><br>Focus . is at risk for elopement related to: Wandering. This care plan had an initiated date of 12/04/2023 and a revision date of 12/19/2023.<br><br>A review of RI #119's Progress Notes revealed a Nursing Progress Note dated 01/26/2026 which documented:<br><br>. At approximately 1945-2000 (7:45 PM - 8:00 PM) resident was located by the local police department . resident was being transferred to (ER), via ambulance for further evaluation .<br><br>The facility investigative summary dated 02/01/2024 documented:<br><br>. Allegation Summary: Resident left center at approximately 4:45 pm unsupervised. Center Investigation: Team members search the center and could not locate (RI #119). Code [NAME] was called and another search was conducted inside the center and the grounds. (Local Police Department) was notified . (local police department) put out a missing person alert on their website and a wider search was started. Team members continued to search the area surrounding the center . until (RI #119) was located approximately 200 yards from the center. Center Findings: During our investigation, we determined that from about 4:00pm-4:45pm, the front receptionist was away from the front area doing other duties. (RI #119) was allowed out the front door by a visitor or family member that wasn't (was not) aware (he/she) was a resident. (RI #119) had a wander guard bracelet on (his/her) left ankle when (he/she) went out the door. At the time the visitors entered . and (RI #119) exited. Emergency Medical Service (EMS) transported (RI #119) to the emergency room to be assessed .<br><br>A review of the hospital report documented:<br><br>. admit date : 26-jan-2024 . (Name of Hospital) Emergency Department (ED) General Note Chief Complaint: Shortness of breath History of Present Illness: . past medical history significant for COPD and dementia. (She/He) presents to the ED via EMS with reports that patient walked away from (His/Her) . facility. (He/She) has noted to have an ankle monitor located on right ankle. Patients only complains about shortness of breath. On exam (he/she) is noted to have a runny nose and productive cough. Patient states left (his/her) facility walking to a party.<br><br>The Alabama Uniform Incident/Offense Report date 01/26/2024 documented:<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Type of Incident or Offense MISSING PERSON . NARRATIVE On 01/26/2024 . MADE CONTACT WITH Registered Nurse (RN # 54) at (name of facility) IN REFERENCE TO (RI #119) EXITING THE BUILDING AT APPROXIMATELY 1640 (6:40 PM) AND WANDERING OFF . (RI #119) IS NOT SUPPOSED TO EXIT THE FACILITY AND THAT (HE/SHE) WEARS A BRACLETET THAT IS SUPOSE TO LOCK DOWN THE BUILDING IF (HE/SHE) GETS NEAR A DOOR . THE BRACELET MUST HAVE MALFUNCTIONED .<br><br>The facility investigative file contained a typed statement, dated 01/27/2024 and signed by Licensed Practical Nurse (LPN) #45. LPN #45 documented: . Rounds were made between 16:30 -1645 (4:30 PM - 4:45 PM) (RI #119) was noted not in (his/her) bed, resident has history (HX) of wandering around facility and going to other units. At approximately 16:50-17:00 (4:50 PM - 5:00 PM) this nurse goes to unit one and unit two to check to see if resident is there or if they have seen a resident staff denies seeing resident. At approximately 17:05-17:10 (5:05 PM - 5:10 PM) administrator was notified of residents not being seen. This nurse then went back to unit and called CODE [NAME] for missing residents. All rooms, bathrooms, and closets were checked. Approximately 17:30 (5:30 PM) (local police department) was notified of the missing resident and this nurse gave description to police . At approximately 19:45-20:00 (7:45 PM - 8:00 PM) staff was notified that resident was found . not far from premises and (he/she) was being transported to (local hospital) for evaluation.<br><br>On 03/27/2026 at 2:54 PM an interview was conducted with a Medication Assistant Certified (MAC). The MAC was asked about the incident regarding RI #119 leaving the building unsupervised on 01/26/2024. The MAC stated she gave RI #119 his/her inhaler at about 3:45 PM and then someone asked if anyone had seen the resident. The MAC said RI #119 was unable to be located, and a code [NAME] was called. The MAC further stated the nurse on the unit called the Administrator (ADM) and then the police were notified. When asked where RI #119 was found, the MAC stated RI #119 was found by the police in a ditch between the facility and the ramp before you get on to the nearby interstate. The MAC stated when the resident left the facility without permission and unsupervised, that would be considered elopement.<br><br>On 03/27/2026 at 3:10 PM a telephone interview was conducted with the Former Administrator (FADM) #50. The FADM was asked about the incident that occurred on 01/26/2024 concerning the elopement of RI #119. She stated that RI #119 was a resident who was considered at risk for elopement and had a wander guard on his/her ankle. FADM #50 said RI #119 was last seen in the facility by staff between 4:00 PM and 4:30 PM and after that time staff were unable to locate the resident. FADM #50 said the alert [NAME] code was called, staff searched for the resident inside and outside the building but were unable to locate him/her. FADM #50 further stated the police were called and the resident was found by the local police department. FADM #50 said the local police had a helicopter searching for RI #119 and the spotlight found RI #119. FADM #50 said RI #119 was found sitting down on the bank close to a nearby interstate and about 150-200 yards from the facility. FADM #50 said the resident was taken to the ER and then returned to the facility. FADM #50 said no staff observed RI #119 leaving the facility, so they were unable to determine how RI#119 left the building. When asked why the resident's wander guard did not sound when RI #119 was at the front door, FADM stated, she was not sure. When asked why the facility did not have measures in place to prevent the resident from leaving the building unsupervised, FADM #50 said the facility had measures in place, but they did not work at that time because the receptionist was away from the desk. FADM #50 said she was ultimately responsible for ensuring residents were safe and when RI #119 left the facility unsupervised, RI #119 could have been physically hurt.<br><br>On 03/31/2026 at 10:28 AM Registered Nurse (RN) #54 stated she was working on the rehab unit on 01/26/2024 and at approximately between 4:00 PM and 4:30 PM, RI #119 was noted not to be on the<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | unit or in his/her room. RN #54 said a CODE [NAME] was initialed, staff searched inside and outside for the resident, and the Director of Nurses (DON), ADM, and the police were notified. RN #54 said she did not know how the resident left the facility, but RI #119 was wearing a wander guard alert bracelet. RN #54 said RI #119 was found on the side of the road, by a nearby interstate. RN #54 was asked what was the potential harm with RI #119 leaving the facility unsupervised and staff unaware of where RI #119 was. RN #54 said, RI #119 could have been injured, hit by a car, picked up by someone (a stranger) and multiple negative things could have happened.<br><br>On 04/01/2026 at 10:09 AM an interview was conducted with LPN #55, a Unit Manager. LPN #55 was asked what she recalled about the incident involving RI #119 on 01/24/2026 when RI #119 left the facility unsupervised. LPN #55 said her shift was over and she received a phone call about RI #119 missing and returned to the facility to help look for RI #119. LPN #55 said several staff got in their cars and searched for RI #119, but RI #119 was not located. LPN #55 said a code [NAME] was called and the DON and Administrator were notified. LPN #55 said RI #119 was found by the police in a ditch on the highway by a nearby interstate. LPN #55 said the facility could not determine how RI #119 exited the facility, and when RI #119 left the facility unsupervised it was considered an elopement. When asked what was the potential harm of RI #119 leaving the facility unsupervised, LPN #55 said RI #119 had Dementia, did not know where he/she was going, and could have gotten lost, hurt or seriously injured.<br><br>2) On 04/21/2025 the SA received an Online Incident Report indicating that at 7:20 PM, RI #88 was with other residents during the designated smoke break. Once all the residents were finished with the smoke break, the Certified Nursing Assistant (CNA) assisted the residents back into the facility. The report indicated RI #88 decided to ambulate his/her wheelchair down the sidewalk and around the corner and did not notify staff he/she was leaving.<br><br>RI #88 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include, Chronic Ischemic Heart Disease, Tobacco Use, Adjustment Disorder with Mixed Anxiety and Depressed Mood and Acquired Absence of Right and Left Leg Below the Knee.<br><br>RI #88's care plan, with an initiated date of 02/02/2024, revealed RI #88 was at risk for smoking and had an intervention to Assist to and from Designated Smoking area, as needed.<br><br>RI #88 also had a care plan, with an initiated date of 02/16/2024, that he/she had ADL (Activities of Daily Living) and Self Care deficits related to having a Bilateral AKA (Above the Knee Amputation), Muscle Weakness, and other Reduced Mobility.<br><br>RI #88's Annual MDS assessment with an ARD of 02/12/2025 revealed RI #88 scored a 15 of on the BIMS, indicating he/she had no cognitive impairment, used a wheelchair for mobility and used a tobacco product during this assessment period.<br><br>RI #88's NOTICE OF COURT ACTION, dated 06/18/2024, revealed RI #88 was an adult in need of protective services and/or placement and required a Guardian who could make responsible decisions for him/her and give consent for his/her care.<br><br>Contained within the facility's investigative file was an INVESTIGATIVE TEMPLATE with a report date of 04/25/2025, and an Incident date of 04/20/2025 at 7:20 PM, which revealed RI #88 was with other residents during the designated smoke break. Once all the residents had finished smoking the CNA (CNA #28) began assisting the residents back into the facility, not noticing that RI #88 decided to (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | ambulate his/her wheelchair down the sidewalk and around the corner without notifying staff he/she was leaving. The CNA assumed that RI #88 was with the other residents as they entered the facility. At around 7:47 PM the Administrator (ADM) was notified by the house supervisor that RI #88 was not in his/her room and had not been seen after the residents were assisted back in the facility after smoking. The ADM instructed the house supervisor to look in all the rooms and bathrooms on the hall RI #88 resided, and to call him back. The ADM was called back around 7:51 PM and was notified by the house supervisor that RI #88 was not in another resident's room or bathroom. The ADM instructed the house supervisor to get a statement from the CNA who assisted the residents back into the facility after their smoke break and began looking outside the facility grounds. The local police department was notified about 8:45 PM to assist. RI #88 was located at a building across from the facility at 9:30 PM. When asked why he/she left the facility without notifying staff, RI #88 said he/she did not want to be at the facility. RI #88 complained of abdominal pain, was sent to the emergency room, and returned to the facility with no new orders. RI #88's care plan was revised to state RI #88 was a safety risk with a history now of leaving the facility. The CNA stated she thought it was strange that RI #88 was wearing his/her prosthetic legs because she had never seen RI #88 wear them or have them on.<br><br>Review of a form titled, ALABAMA UNIFORM INCIDENT/OFFENSE REPORT, dated 04/20/2025 at 9:52 PM revealed the following:<br><br>. NARRATIVE ON 04/20/2025 I, (NAME OF OFFICER), WAS DISPATCHED TO (NAME OF FACILITY) FOR A MISSING PERSON. I MET THE COMPLAINANT (FADM #27) WHO ADVISED A RESIDENT, IDENTIFIED AS (RI #88), WAS UNACCOUNTED FOR AND LAST SEEN ON SCENE AT APPROXIMATELY 1920 (7:20 PM) . (NAME OF OFFICER) MADE CONTACT WITH INDIVIDUALS AT (NAME OF LAUNDROMAT) AT APPROXIMATELY 2050 (8:50 PM) AND THEY ADVISED THAT (RI #88) WAS SEEN IN THE AREA AN HOUR PRIOR . ADDITIONAL INCIDENT/OFFENSE NARRATIVE CONTINUED (NAME OF OFFICER) LOCATED (RI #88) BEHIND (NAME OF LAUNDROMAT) AT 2143 (9:43 PM). (RI #88) WAS TRANSPORTED TO (NAME OF LOCAL HOSPITAL) FOR FURTHER EVALUATION.<br><br>Contained within the facility investigative file was a handwritten statement written by CNA # 28, which documented the following:<br><br>On 4-20-25 After Around 7:20 I were assisting 14 Resident (residents) out smoking and assisting Them back in I assumed (RI #88) (was) with the other Resident (Residents) Coming in. I did think it was strange that (RI #88) was wearing (His/Her) postheties (prosthetic) legs But I Never before seen (him/her) c (with) them on.<br><br>On 03/26/2026 at 9:00 AM, on 03/27/2026 at 10:00 AM and on 03/30/2026 at 1:15 PM unsuccessful telephone attempts was made to contact CNA #28.<br><br>Contained in the facility investigation file was a typed statement, dated 04/20/2025 given by Former Licensed Practical Nurse (FLPN) #31 which revealed the following:<br><br>(RN #11) called Unit 1 and told me, (Former Assistant Director of Nursing [FADON #43]) just saw your resident outside the facility in the street. She stated it was (RI #88). I then ran outside to smoking area and asked the CNA where resident was, CNA replied he/she smoked then came back into the facility. I told med tech to go speak with (RN #11) and I ran outside looking for resident. While I was outside looking for resident, (FADON #43) pulled up in her car and I rode with her to further<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | search for resident. After several minutes of searching, we returned to facility. The last time I remember seeing resident was approximately 7 PM when he/she was in line to smoke with other smokers on Unit 1.<br><br>On 03/25/2026 at 9:30 AM, on 03/25/2026 at 2:45 PM and on 03/30/2026 at 4:00 PM unsuccessful telephone attempt were made to contact RN #11.<br><br>On 04/01/2026 at 2:00 PM, on 04/06/2026 at 9:00 AM and on 04/07/2026 at 11:00 AM unsuccessful telephone attempt were made to contact FADON #43.<br><br>On 03/26/2026 at 11:30 AM a telephone interview was conducted with FADM #27. When asked was he the Administrator when RI #88 left the facility without staff knowledge on 04/20/2025, FADM #27 replied yes. When asked what could have been the worst possible thing that could have happened to RI #88 leaving the facility the way he/she did, FDAM #27 said that RI #88 could have fallen in the ditch or been hit by a car driving through the parking lot or side road. FADM #27 said RI #88 could have also fallen, out of his/her wheelchair, onto the asphalt. When asked who was ultimately responsible for assuring all residents were safe and accounted for, FADM #27 stated that all the staff at the facility were responsible for the resident's safety.<br><br>3) On 08/22/2025 at 3:06 PM the SA received an online incident report from the facility that indicated RI #127 was assisted to the front porch of the center by a staff member and chose to wheel himself/herself off the premises. The Administrator was notified when staff noticed RI #127 was no longer sitting in front of the facility. Staff went to assist resident back to the facility with no injury noted.<br><br>RI #127 was admitted to the facility on [DATE], with diagnoses including Hypertensive Heart Disease with Chronic Kidney Disease and Heart Failure, Unspecified Systolic Congestive Heart Failure, Cognitive Communication Deficit, Hemiplegia and Hemiparesis following Cerebral Infraction Affecting the Right Dominant Side, and Hypertension.<br><br>RI #127's Quarterly MDS with an ARD of 08/12/2025 revealed RI #127 was unable to complete the BIMS assessment.<br><br>On 03/25/2026 at 2:56 PM an interview with CNA #15 revealed she was familiar with RI #127 and provided care including assistance with activities of daily living (ADLs) and grooming. CNA #15 said she would also take RI #127 outside and sit with him/her at times. CNA #15 stated she first became aware RI #127 was missing when she observed the resident in a wheelchair on the side of a highway near the facility while riding with another co-worker during her break. CNA #15 stated she immediately stopped and attempted to redirect RI #127 to return to the facility. CNA #15 stated she called the facility but did not recall who she spoke with. CNA #15 further stated she contacted another employee CNA #51 to ensure administration was notified. CNA # 15 revealed prior to the incident on 08/22/2025 she had informed LPN #16 that RI #127 had expressed the desire to go to Mississippi. When asked about the traffic conditions the highway, CNA #15 responded it was a busy roadway and expressed the incident could have been prevented if RI #127 had not been allowed outside alone.<br><br>On 03/25/2026 4:00 PM an interview was conducted with LPN #16 revealed RI #127 expressed a desire to return home to be closer to family but was unsure of the location of RI #127's family. LPN #16 recalled being informed that efforts were being made to arrange placement closer to RI #127's<br>(continued on next page) |

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| | 015132 | A. Building<br>B. Wing | 04/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | home. LPN #16 stated she did not personally inform social services but believed social services were aware of RI #127's desire to go home. According to LPN #16, RI #127 had been under the impression that discharge home independently was possible, but this was not considered a safe discharge plan. She reiterated the understanding was social services were working toward arranging placement closer to RI #127's home.<br><br>On 03/25/2026 at 4:38 PM during an interview Receptionist (RCP) #17 reported that the FDON #24 had escorted RI #127 to the porch and remained there for approximately five minutes before returning inside of the facility. During that time, RI #127 was observed talking with two CNAs who were seated outside; however, the receptionist was unable to identify the CNAs. RCP #17 estimated that RI #127 remained outside for approximately 5-10 minutes with the two CNAs before the CNAs reentered the facility. She said she left the reception desk for approximately 8 minutes and when she returned within 1-2 minutes, she received a phone call from an unidentified caller asking whether the facility had a missing resident. The caller described the resident, and she recognized the description as RI #127, noting that RI #127 had been the only resident outside on the porch. She immediately spoke with a nurse on Unit 3 and contacted the FADM #8 that RI #127 was on the side of the Highway. RCP #17 stated the presence of cameras at the front of the facility could have helped prevent the incident.<br><br>On 03/26/2026 at 10:22 AM CNA #23 reported she was assigned to RI #127 on the day of the incident. CNA #23 stated she received a personal phone call from her godmother, who asked if the facility had a missing resident. CNA #23 stated she immediately looked out the back door and observed RI #127 outside with his/her wheelchair. CNA #23 stated she exited the facility through the Unit 5 back door without notifying other staff and ran toward RI #127, who was located near the Highway on the shoulder of the road. Upon reaching RI #127, the resident refused to return to the facility. CNA #23 reported RI #127 had been expressing the desire to go home for several weeks and was verbally stating home. CNA #23 stated she did not contact the facility and instead returned to the facility to seek help, leaving RI #127 on the Highway. CNA #23 reported she informed the FDON #24 and FADON #49. CNA #23 returned to the Highway where RI #127 had moved further along in his/her wheelchair. CNA #23 was unable to estimate the distance RI #127 had traveled from the facility to the area on the Highway. CNA #23 reported law enforcement arrived, along with additional staff. CNA #23 described RI #127 as wearing a red shirt, blue jeans, and pair of black and white tennis shoes. RI #127 appeared well-groomed, breathing normally, not sweating, and not visible distress, but was focused on going home. CNA #23 reported that the FDON #24 was able to redirect RI #127 off the Highway, and RI #127 was assisted back to the facility in his/her wheelchair with a police escort. When asked if the incident could have been prevented, CNA #23 stated it possibly could have been prevented, noting that the doors were coded and RI #127 had been allowed to go out to the porch by FDON #24 despite expressing a desire to go home.<br><br>On 03/26/2026 at 5:45 PM Social Services Assistant (SSA) #6 reported RI #127 was admitted for rehabilitation, and RI #127's sister was identified as the responsible party. SSA #6 documented on 07/31/2025 at 10:24 AM and read back verification that RI #127 repeatedly requested to be taken home by staff. SSA #6 stated she met with RI #127 regarding discharge planning and explained that RI #127 would require assistance if discharged to the community. SSA #6 reviewed documentation and confirmed the documented note on 07/31/2025 regarding RI #127 request to go home was accurate. When asked if social services was aware that RI #127 wanted to go home prior to the incident on 08/22/2025, SSA #6 responded yes. When asked if the incident could have been prevented, SSA #6 stated yes and indicated that increased security at the front door may have prevented the incident.<br><br>On 04/01/2026 at 09:41 AM during a telephone interview FDON #24 reported RI #127 asked to go<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | outside and was escorted to the porch. FDON #24 did not recall how long he/she remained on the porch with RI #127 but confirmed that RI #127 was left unattended on the porch with no staff monitoring. FDON #24 stated he was notified of the incident when a staff member informed him that RI #127 had left the facility. RI #127 was located down the street in front of the facility, on the main highway, on the shoulder of the road, approximately 100 feet from the highway. FDON #24 described the area as an active travel roadway and stated that being on the shoulder of the road in a wheelchair presents a safety risk due to traffic. FDON #24 stated the weather was sunny, with no rain. FDON #24 reported that upon assessment, RI #127 did not appear overheated, was not in distress, and was not complaining of any symptoms. When asked if the incident could have been prevented, FDON #24 stated yes the incident could have been avoided if RI #127 had not been taken outside and left unattended.<br><br>On 04/01/2026 at 10:50 AM during a telephone interview FADM #8 reported he was made aware RI #127 had left the facility while attending a morning meeting, when a staff member informed him RI #127 was on the highway. When asked how RI #127 exited the facility, FADM #8 stated that the FDON #24 had taken RI #127 outside to sit on the porch. FADM #8 reported that RI #127 was found on the roadway but was safe and without apparent injury. FADM #8 stated there were no observed physical injuries, including bruising, fractures, or signs of heat exhaustion and he/she did not appear frightened or in distress at the time of retrieval. When asked how the weather was, FADM #8 stated the weather was nice, not raining.<br><br>On 03/22/2026 at 10:26 AM, the surveyor |

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| F 0688<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy titled Restorative Guidelines the facility failed to implement a functional maintenance program (FMP) following discharge from therapy for Resident Identifier (RI) #60 one of one residents who experienced multiple falls. This failure had the potential to contribute to decline in function and increased risk for further falls and had the potential to affect all residents requiring ongoing maintenance services due to the absence of a functional maintenance program. This deficient practices were cited as a result of the investigations of facility reported incident/complaint/report number 2800273.Findings Include:Cross-Reference F689 and F725A review of a facility policy titled RESTORATIVE GUIDELINE with an effective date of 2024 revealed,PURPOSE:Restorative services refer to nursing interventions that assist the resident in sustaining function and/or continue to progress toward functional goals.RESTORATIVE PROGRAM:A successful restorative program is dependent on the collaboration of the Care Coordination team to identify residents who will benefit from the program utilizing the Restorative process flow chart below.The Director of Care Coordination (DCC) is the owner of the Restorative program. A Nurse Partner will be the backup.Each resident will be screened or evaluated by the DCC/IDT for inclusion into the appropriate center restorative program where there is a need identified .Restorative initial review completed in PCC.Restorative Plans of Care will be added to the Patient/Resident Care Plan . The DCC/Nurse Partner will evaluate and document through the Restorative Monthly Review Evaluation in PCC this will include initiating and updating restorative care plans.Team members are trained in the Restorative Plan of Care .IMPLEMENTATATION AND ROLES OF THE RESTORATIVE PROGRAM When a resident is identified to have a functional change of condition, a restorative form is completed and given to the DCC/Nurse Partner. Discussion in the Daily Clinical Start up will occur to determine next steps. A licensed therapy team will: Complete a Therapy Screen/Evaluation Be available to restorative team/nurse as a consultant.Administrator, DON, DCC /Nurse Partner will provide Restorative Program oversight .Nursing team members will be trained in restorative modules. The DCC/ Nurse Partner will be responsible for assuring appropriate team members provide care. Non-nursing team members . will be trained in select modules where approved .Key Elements: Residents will benefit from a Restorative Program in order to sustain function and /or to continue to progress toward functional goals after formalized therapy.When a resident is identified as a restorative participant, an individualized care plan will be developed to include measurable objectives and interventions .RI #60 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses to include: Muscle Weakness (Generalized), Bipolar Disorder, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, and Lack of Coordination.RI #60 Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/29/2025 documented a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating intact cognitive function.On 04/07/2026 at 5:20 PM the Director of Therapy (DOT) stated RI #60 was treated by the therapy department from 02/10/2026 to 03/27/2026 due to decline in strength and mobility. The DOT said the facility did not have a restorative nurse and RI #60 was not being followed by an FMP. On 04/07/2026 at 6:10 PM the Assistant Director of Nursing (ADON) stated RI #60 did not have a restorative care plan. The ADON further stated the facility did not have a restorative nurse, restorative program, or an FMP. On 04/08/2026 at 6:09 PM the Registered Nurse Assessment Coordinator/ MDS Coordinator stated the facility did not have a restorative nurse nor a restorative program. She further stated the facility did not have enough staff for a restorative nurse and the restorative program had not been in place for at least eight years. When asked about the concern of not following the facility policy for FMP with residents with decline in mobility and frequent falls, she stated a resident could get hurt or not reach their rehab potential.On 04/09/2026 at 9:59 AM the Staffing Coordinator stated the facility did not currently have a restorative nurse and had not had one for four years. |

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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>Based on interview, record review and the Center Assessment Tool the facility failed to provide sufficient nursing staff to meet resident needs when the Registered Nurse (RN) #40 did not respond to a residents call light or notification of a fall, stating she did not have time because she was responsible for 50 residents. In addition, the facility did not have a restorative program to ensure residents maintained mobility and range of motion in place due to lack of staffing availability. These failures limited the facility's ability to provide timely care and services and had the potential to affect all residents who require nursing supervision and restorative services. This deficient practices were cited as a result of the investigations of facility reported incident/complaint/report number 2800273.Findings Include: The Center Assessment Tool update 3/9/2026 documented: .Other .When adjusting staffing for daily care needs, appropriate staff skill sets are reviewed to assure that licensed and no-licensed staff are always present, 24/7, including nights and weekends, with skills to care for physical and psychological needs of patients and residents. Specific staffing needs are based upon individual patients' and residents' diagnosis, care plans and any change of condition that may have occurred. Patients/residents who may have issues with behaviors are also taken into consideration when staffing is being reviewed. Should any of these variables change center leadership adjusts staffing accordingly. Input from center leadership, including but not limited to the governing body, administrator, DNS, medical director, and direct care team members is taken into account when assigning staff to units in the center. Team members are assigned according to workload. The level of assistance needed is determined on a resident-by-resident basis and staffed accordingly. Residents are assessed for level of care needed by team members.Staffing Plan3.2 Based on the resident/patient population and their needs for care and support, describe the general approach to staffing to ensure there are sufficient team members to meet the needs of the residents/patients at any given time.Our approach to determine the staffing needs to care for and support our patients and residents, along with the information provided in Section 1.8 above, begins at the bedside. The administrator facilitates the coordination of care needed each day with the interdisciplinary team. The care team evaluates the resident/patient population and acuity as well as center layout to determine the number of team members needed to provide care and service to the patients/residents. This then creates our center staffing ladder. If the profile of the resident/patient population changes throughout the year, the number of team members changes accordingly, and the staffing ladder is adjusted. The center has internal approaches that are utilized should non-emergent staffing needs arise; On-Call licensed staff coverage, overtime by internal staff, shift pick up for staff who volunteer to work additional hours, region nurses are utilized in various centers to assist with openings, or clinical leadership work as floor nurses.On 03/26/2026 at 3:56 PM RN #40 reported she was working on 03/05/2026. When asked if Certified Nursing Assistant (CNA) #39 informed her that Resident Identifier (RI) #60 had been found on the floor, RN #40 stated she could not recall her exact words. When asked if she assessed RI #60 after being informed, RN #40 stated the situation was not significant enough to disrupt the medication pass. RN #40 reported she was responsible for approximately 50 -55 residents during the shift. When questioned regarding a call light for RI #60 being activated for a prolonged period on 03/05/2025 she stated she did not observe that. RN #40 stated she would assist with answering call lights if she was nearby; however, she reported she was unable to respond while counting narcotics or receiving report. RN #40 stated that while administering medications, she was unable to keep up with alarms.On 04/08/2026 at 6:09 PM the MDS Coordinator stated the facility did not have a restorative program. The MDS Coordinator reported the facility did not have sufficient staff to support a restorative nurse position and indicated it had been eight or more years since the facility last had a restorative nurse. The MDS Coordinator further stated that although the facility previously had three restorative nurses, the program was not maintained after their departure due to inadequate staffing. |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, reviews of residents' medical records, review of a facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to protect the rights of residents to be free from abuse perpetrated by an employee of the facility and by other residents in the facility. Specifically: 1) On 08/05/2025 Resident Identifier (RI) #70 was physically abused by RI #106 and RI #126, when RI #106 and RI #126 struck RI #70 in the chest with their open hands. The facility failed to protect RI #70 from physical abuse. 2) On 11/19/2025 RI #102 was physically and verbally abused by a housekeeper, when the housekeeper hit RI #102 with her hand, on his/her back, and used profane language toward RI #102. The housekeeper yelled and cursed saying Don't ever do that shit again. to RI #102. The housekeeper reported the abuse to the Former Administration (FADM #8) who said RI #102 was physically and verbally abused and what RI #102 experienced would make someone upset and fearful. 3) On 03/28/2025 RI #95 was physically abused by RI #112 and RI #95. RI #112 and RI #95 were sitting in their wheelchairs in the front lobby and were heard arguing with each other. RI #112 was observed by the charge nurse to stand and hit RI #95 on the head. These deficient practices were cited as a result of the investigations of facility reported incident/complaint/report numbers 2588929, 2682390 and 2794432. These failures affected four of 17 residents reviewed for abuse concerns during the survey.Findings Include:<br><br>A review of a facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy with an effective date of January 2019 revealed, Purpose: To prohibit and prevent abuse, neglect, exploitation, . in accordance with Federal and State Laws. Definitions: Physical Abuse: . is not limited to, hitting, slapping, punching, biting, and kicking. Verbal 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.<br><br>1) On 08/05/2025 at 2:03 PM the SA received a FRI alleging physical abuse occurred when RI #106 and RI #126 were hitting RI #70 in the chest when returning from a smoke break. When the residents got to the lobby area, it was reported that RI #106 and RI #126 were hitting RI #70 in the chest. The residents were separated, a body audit was completed for RI #70 and an investigation was initiated.<br><br>On 08/05/2025 at 6:21 PM a review of a document titled, (ALABAMA UNIFORM INCIDENT/OFFENCE REPORT) was filed stating that RI #106 and RI #126 were lightly striking RI #70 on his/her chest with the palms of their hands.<br><br>RI #70 was admitted to the facility on [DATE] and remitted on 04/17/2023 and had diagnoses that included Major Depressive Disorder, Psychosis Not Due to a Substance or Known Physiological Condition and Dementia.<br><br>RI #70's Annual MDS with an ARD of 07/10/2025 documented a BIMS score of nine which indicated moderate cognitive impairment.<br><br>RI #106 was admitted to the facility on [DATE] with diagnoses including Hypertensive Heart Disease without Heart Failure, Adjustment Disorder with Depressed Mood and Unspecified Sequelae Cerebral Infraction.<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | RI #106's admission MDS with an ARD date of 05/06/2025 documented a BIMS score of 10 which indicated moderate cognitive impairment.<br><br>RI #126 was admitted to the facility on [DATE] with diagnoses to include Atherosclerotic Heart Disease of native Coronary Artery without Angina Pectoris, Bradycardia and Vascular Dementia.<br><br>The facility's investigation file contained an interview conducted with CNA #13, (Certified Nurse Aide) with no date documented I took the smokers out. I was coming from bringing the smokers in and through the doors leading into the lobby from the dining room. I saw RI #126 and RI #106 hitting RI #70 in his/her chest. They were hitting him/her with their open hands, not fists. I don't know why they were hitting him/her. I broke it up and told RI #70 to go to his/her room. RI #70 looked like he/she was trying to get away from them to me.<br><br>A review of the Investigation document file summary with no date, RI #106 was attempting to get the apron off RI #70 as he/she rolled by. When staff member came around the corner, she thought that RI #70 was being hit by RI #106 and trying to get away from him/her, when he/she was actually trying to grab hold of the apron. Neither was upset or agitated with each other; however, RI #70 was upset at the staff member for asking him/her to return to his room. Within 15 minutes all 3 residents were continuing with their usual daily routine. PHYSICAL ABUSE NOT SUBSTANTIATED.<br><br>On 04/01/2026 at 11:19 AM CNA #13 stated when she was bringing the smokers back into the building she saw RI #106 and RI #126 hitting RI #70 with their open hands. CNA #13 stated she separated the residents and reported the incident to the nurse. According to CNA #13 it was physical abuse when RI #106 hit RI #70.<br><br>On 04/01/2026 at 11:07 AM during an interview RI #70 recalled being hit by RI #106 and RI #126 when they were coming back from a smoke break. RI #70 stated they used their fist and the hits were not hard. RI #70 said the incident occurred in the hall.<br><br>On 04/01/2026 at 4:36 PM during a follow-up interview RI #70 was asked how it made him/her feel when RI #106 and RI #126 hit him/her. RI #70 stated not good.<br><br>On 04/06/2026 at 4:18 PM during a follow-up interview RI #70 stated that he/she felt abused when RI #106 and RI #126 hit him/her.<br><br>On 04/01/2026 at 4:47 PM during an interview RI #106 said he/she did not remember hitting anybody or letting another person use his/her apron.<br><br>On 04/01/2026 at 3:03 PM FADM #14 was asked about the incident between RI #70, RI #106 and RI #126. She stated each resident must have his/her own apron to go out and smoke. RI #70 did not have his/her apron and borrowed RI #106's apron. RI #126 did not know what was going on and joined in hitting RI #70. FADM #14 stated that she investigated the case and it was not substantiated because it did not meet the criteria for abuse. FADM #14 stated the abuse policy under physical abuse stated physical abuse included, but not limited to, hitting, slapping, punching, biting and kicking.<br><br>On 04/07/2026 at 8:28 AM during a follow up interview FADM #14 said it would make a reasonable person feel like they were being attacked if someone hit them in the chest.<br><br>2) Review of the facility's investigative file revealed a report was made to the State Agency through<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the Online Incident Reporting System on 11/19/2025 at 4:19 PM alleging RI #102 was physically and verbally abused by a Housekeeper. It was reported that RI #102 was physically and verbally abused by a housekeeper, when the housekeeper hit RI #102 with his/her hand, on RI #102's back, and used profane language toward RI #102. The housekeeper yelled and cursed Don't ever do that shit again. at RI #102.<br><br>RI #102 was admitted to the facility on [DATE] with diagnoses to include: Vascular Dementia, Generalized Anxiety, Mood Disorder and Heart Failure.<br><br>RI #102's Quarterly Minimum Data Set with an Assessment Reference Date of 10/22/2025 documented a Brief Interview for Mental Status score of 12 out of 15 which indicated moderate cognitive impairment.<br><br>Included in the facility's investigative file was a handwritten statement signed by the housekeeper, (dated 11/19/2025), which documented the following allegation: I was walking past RI #102 and RI #102 groped my butt and girl parts with his/her hand and arm. As a reflex to what happened (Housekeeper) popped RI #102 in the back and said Don't ever do that shit again. signed Housekeeper (name).<br><br>On 04/01/2026 at 10:24 AM, 11:41 AM, and at 4:05 PM unsuccessful attempts were made to contact the housekeeper.<br><br>Included in the facility's investigation report title Investigation Template dated 11/19/2025 file that documented the following: Investigation complete, Housekeeper was terminated. Physical and Verbal Abuse Substantiated. Investigation Findings: Substantiated.<br><br>Review of a facility form titled EMPLOYEE CORRECTIVE ACTION (ECA) dated 11/19/2025 for the housekeeper, revealed a box was checked for the following: . DEGREE OF DISCIPLINE . Discharge . Plan of Correction . Due to the . violations .to terminate your employment effective immediately.<br><br>On 04/01/2026 at 10:42 AM FADM #8 was asked about the incident that occurred between RI #102 and the housekeeper. FADM #8 stated the housekeeper self-reported this to him and there were no witnesses. FADM #8 stated the housekeeper, told him that she hit RI #102 with her hand, on his/her back, and used profane language toward RI #102. The housekeeper stated she yelled and cursed Don't ever do that shit again. at RI #102. FADM #8 further said it was considered physical and verbal abuse and that would make a reasonable person feel upset and fearful.<br><br>3) On 03/28/2025 at 10:51 AM the SA received an Online Incident Report involving RI #112 hitting RI #95. RI #112 and RI #95 were sitting in their wheelchairs in the front lobby when RI #112 began arguing with RI #95, stood, then hit RI #95 in the face area.<br><br>RI #112 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Vascular Dementia, mild, Agitation, Unspecified Mood (Affective) Disorder, Dementia, Moderate, with other Behavior Disturbances and Anxiety.<br><br>RI #112's Quarterly MDS assessment with an ARD of 03/19/2025 revealed RI #112 had a BIMS of 15 of 15, indicating RI #112 was cognitively intact.<br><br>RI #95 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include<br>(continued on next page) |

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| | 015132 | A. Building<br>B. Wing | 04/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Diversicare of Oxford | 1130 South Hale Street<br>Oxford, AL 36203 |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Vascular Dementia, Moderate, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety.<br><br>RI #95's Significant Change MDS assessment with an ARD of 02/07/2025 revealed RI #95 had a BIMS of 9 of 15, indicating RI #95 had moderately impaired cognition.<br><br>Contained within the facility's investigative file was an INVESTIGATION TEMPLATE with a report date of 04/03/2025, and an incident date of 03/28/2025 at 8:55 AM. The report revealed on 03/28/2025, LPN #52, the charge nurse who witnessed the resident-on-resident incident provided her statement. LPN #52 was sitting at the Unit 2 nurse's station located across from the front lobby common area. She noted RI #112 and RI #95 were talking while sitting in their wheelchairs in the front lobby common area. RI #112 started raising his/her voice at RI #95, words were exchanged by both residents, then RI #112 stood up from his/her wheelchair and hit RI #95.<br><br>On 03/26/2026 at 10:01 AM an unsuccessful telephone attempt was made to contact LPN #52.<br><br>On 03/26/2026 at 4:37 PM a telephone interview was conducted with FADM #27. When asked did he remember anything about the incident between RI #112 and RI #95 on 03/28/2025, FADM #27 said yes, vaguely. FADM #27 said RI #112 was talking loudly and getting agitated and the nurse tried to calm him/her down. FADM #27 said he guessed RI 95 was tired of it and said something back to RI #112, then RI #112 got up from his/her wheelchair and before the nurse could intervene RI #112 hit RI #95. The surveyor asked FADM #27 from what he heard from the nurse and other witnesses, would he consider the incident abuse, the ADM said he would consider this abuse. |

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| F 0867<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.<br><br>Based on interviews, record review, and a review of the facility policy titled, Quality Assurance and Performance Improvement (QAPI), the QAPI committee failed to identify all causal factors related to four elopements for Resident Identifiers (RI) #119, RI #88, RI #127 and RI #106 and to determine what corrective actions needed to be taken to prevent any further resident safety concerns.This deficient practice affected RI #119, RI #88, RI #127 and RI #106.These deficient practices were cited as a result of the investigations of facility reported incident/complaint/report numbers 447995, 447964, 2629802 and 2603429.Findings Include: Cross-Reference F689 and F725, A review of a facility policy titled, Quality Assurance and Performance Improvement, dated March 2025 revealed: Purpose The center develops, implements, and maintains an effective, comprehensive, data-driven QAPI program that focus on indicators of the outcomes of care and quality of life and addresses all the care and unique services the center provides. Definitions Adverse Event is an untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof. High Risk Areas refers to care of service areas associated with significant risk to the health or safety of patient/resident . Performance Improvement (PI) is the continuous study and improvement of processes with the intent to improve services or outcomes, and prevent or decreased the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement. Quality Assurance (QA) is the specification of standards for quality of service and outcomes, and systems throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards. QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why center performance is at risk or has failed to meet standards. Quality Assurance and Performance Improvement (QAPI) refers to the coordinated application of two mutually reinforcing aspects of a quality management system: (QA) and Performance Improvement (PI). QAPI takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing home, . Procedure .c. Develop and implement appropriate plans of action to correct identified quality deficiencies . 3. The QAPI plan will address the following elements: . c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies. Key components of this process include, but are not limited to, the following: . Tracking and measuring performanceEstablishing goals and thresholds for performance improvements.Identifying prioritizing quality deficienciesSystematically analyzing underlying cause of systemic quality deficiencies.Developing and implementing corrective action or performance improvement activities.Monitoring and evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. 4. The center will maintain documentation and demonstrate evidence of its ongoing QAPI program. Documentation may include, but is not limited to: . b. Systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events. d. Documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. On 04/09/2026 at 2:47 PM the Director of Clinical Operations (DCO) #2 said the facility identified the issues/problems with elopements. DCO #2 was asked what the root cause of the elopements were and why elopements continued to occur in the facility after the first elopement in January of 2024. She said because each elopement was different and different interventions were put in place but was not a pattern. On 04/09/2026 at 4:34 PM a follow- up interview was conducted with DCO #2. She said insufficient staffing or lack of supervision was not considered as a factor for the root cause of the elopements. |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of facility's policies titled, Abuse, Neglect, Misappropriation, Exploitation Policy, Medication Destruction, facility investigation files, and review of information from the Alabama Department of Public Health's (ADPH) Online Reporting System, the facility failed to ensure residents' medications were secured from misappropriation and failed to identify, report, and investigate allegations in accordance with policies and regulatory requirements. The facility further failed to ensure proper medication destruction, failed to maintain accountability of discontinued medications, and failed to initiate timely reporting to the Alabama Department of Public Health.The deficient practice affected Resident Identifiers (RI) #12, #129, and #130 three of three residents reviewed for misappropriation of property.Specifically:Former Licensed Practical Nurse (FLPN) #31 removed entire cards of residents' discontinued medications including Clonidine 0.1mg (milligrams), Prednisone 40mg, and Atorvastatin 40mg discontinued, non-controlled medications from the facility. The medications were not identified as missing by the facility and were later discovered in the home of FLPN #31 during a police investigation. This deficient practices was cited as a result of the investigations of facility reported incident/complaint/report number 2683455.Findings Include: The facility policy titled Medication Destruction, dated 11/97 and Reviewed/Updated: 04/22, revealed the following: Policy:It is the policy . to comply with all state and federal laws and regulations in regard to medication destruction. The facility is responsible for maintaining accurate records of medications destroyed with proper witness signatures. assists with medication destruction at least monthly. Medications cannot be returned . to be destroyed.PROCEDURE:Discontinued and expired medications, as well as medications of discharged , transferred, or deceased residents shall be destroyed within a period of time not to exceed thirty (30) days.Prior to destruction, the medications are stored in a designated area separate from other medications.All medications to be destroyed MUST be documented on the Medication Destruction Record. The facility policy titled Abuse, Neglect, Misappropriation, Exploitation Policy, with an Effective Date: January 2019, revealed the following: Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation or 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.Definitions: .Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without resident consent. On 11/19/2025 at 7:14 PM the SA received an online report that prescription medications that belonged to residents in the facility were found in the possession of FLPN #31.RI #12 was admitted to the facility on [DATE] with diagnoses that included Hypertensive Heart Disease without Heart Failure, Type 2 Diabetes Mellitus with Hyperglycemia and Muscle Weakness.A review of RI #12's May 2025 Medication Administration Record (MAR) revealed an order for Atorvastatin Calcium 40mg 1 tablet by mouth everyday with start date of 12/27/2024 and discontinue (DC) date of 07/27/2025RI #129 was admitted to the facility on [DATE] with diagnoses that included Localized Swelling Mass and Lump Left Lower Limb, Diabetes Mellitus with Diabetic Neuropathy and Anxiety Disorder Due to Known Physiological Condition.A review of RI #129's January 2024 MAR revealed an order for Prednisone 20mg tablet Give 40mg by mouth everyday with start date of 12/31/2023 and DC date of 01/06/2024 RI #130 was admitted to the facility on [DATE] with diagnoses that included Wedge Compression Fracture of First Lumbar Vertebra, Chronic Obstructive Pulmonary Disease with Acute Exacerbation and Urinary Tract Infection.A review of RI #130's August 2025 MAR revealed an order for Clonidine HCL Oral Tablet 0.1mg give 1 tablet every 12 hours as needed for Elevated SBP related to Essential Hypertension with a start date of 08/08/2025 and DC date of 08/27/2025On 03/25/2026 at 02:35 PM Pharmacist (PHARM) #56 reported she was notified of the allegation involving Former Licensed Practical Nurse (FLPN) #31 but could not recall the exact date. PHARM #56 stated law enforcement<br>(continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | initially notified the facility, and required reporting was completed per policy. On 03/26/2026 at 5:33 PM FLPN #31 confirmed she was terminated for allegations of taking resident medications. She acknowledged providing medication administration to RI #12, RI #129, and possibly RI #130. She stated she should have reported and returned the medications.On 03/26/2026 at 12:15 PM Former Administrator (FADM) #14 verified she reviewed medications that were found in FLPN's #31 home. She reported that her role was to determine whether the medications belonged to current residents and whether the medications were active orders. FADM #14 confirmed the medications were identified as belonging to facility residents but had been discontinued, with no replacement of medications required.On 04/08/2026 at 9:30 AM Former Director of Nursing (FDON ) stated the facility was first notified when police arrived and informed FADM #8 medications belonging to the facility had been found in the home of FLPN #31. The police provided photographic evidence of medication cards that had been removed from the facility. FDON #22 confirmed that three non-narcotic medication cards belonging to the facility residents were identified in the possession of FLPN #31. These medications had been discontinued; however, the medications remained resident/facility property and should not have been removed from the facility but destroyed per facility policy. She acknowledged that discontinued medications were required to be secured and destroyed according to policy. The medications found in FLPN #31's home should have been destroyed and not removed from the facility. On 04/08/2026 at 10:58 AM Director of Clinical Operations (DCO) #2 revealed she was notified by the Administrator and Director of Nursing Services after the police arrived at the facility reporting medications found in the home of FLPN #31 with photographic evidence that confirmed the presence of non-narcotic medication cards originating from the facility. She confirmed the non-narcotic medications were discontinued and should have been secured and destroyed at least weekly or no later than monthly. The medications found in FLPN's #31 home should have been destroyed and not removed from the facility. She further acknowledged that medications prescribed to residents were found outside of the facility in the possession of FLPN #31, supporting the allegation of misappropriation of resident property. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on interviews, record review, review of a facility policy titled, Abuse, Neglect, Misappropriation, Exploitation Policy, and review of Facility Reported Incidents (FRIs), the facility failed to report an incident of physical abuse to the State Agency (SA) and an allegation of misappropriation to the SA within required timeframes. These failures had the potential to delay initiation of investigations and implementation of protective measures to ensure resident safety and protection.Specifically:1.) The facility failed to report an incident of physical abuse involving Resident Identifier (RI) #128 and RI #132 within two hours of the incident occurring. On 11/10/2025 around 11:35 AM RI # 132 entered the room of RI #128 and pinched him/her on the hand when RI #132 attempted to redirect RI #128 out of the room. The facility reported this allegation to the SA on 11/10/2025 at 5:12 PM. 2.) The facility further failed to report an allegation of misappropriation involving RI #12, RI #130 and RI #129 within 24 hours of the incident occurring. On 11/18/2025 at 5:00 PM the facility became aware that Former Licensed Practical Nurse (FLPN) #31 had in her possession medication that belonged to RI #12, RI #130 and RI #129. The facility reported this allegation to the SA on 11/19/2025 at 7:14 PM. These failures affected five of 17 residents sampled for abuse and neglect.These deficient practices were cited as a result of the investigations of facility reported incident/complaint/report numbers 2667273 and 2683455.Findings Include:Cross Reference F600 and F602A Policy titled Abuse, Neglect, Misappropriation, Exploitation Policy with an effective date of January 2019 documented: .Purpose: To prohibit and prevent abuse, neglect, exploitation, misappropriation of resident property and to ensure reporting and investigation of alleged violations.in accordance with Federal and State laws.Definitions: .Misappropriation of Resident Property: The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the residents consent.Physical Abuse: Includes, but is not limited to, hitting, slapping, punching, biting, and kicking. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. 7. Reporting/ResponseAlleged 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 required agencies.within specified time frames. 1) On 11/10/2025 at 5:12 PM, the SA received a FRI that alleged RI #132 came into RI #128's room and pinched him/her on the hand. The facility became aware of the allegation on 11/10/2025 at 11:35 AM. On 04/08/2026 at 10:13 AM the Director of Clinical Operation (DCO) #2 stated the Administrator became aware of the incident involving RI #128 and RI #132 on 11/10/2025 at 11:51 AM when it was reported to him. DCO #2 said the incident was reported to the State Agency on 11/10/2025 at 5:12 PM and should have been reported within two hours; however, it was not reported within the two hour time frame.2) On 11/19/2025 at 7:14 PM the SA received an allegation of misappropriation. The allegation alleged that FLPN #31 had in her possession medication that belonged to RI #12, RI #130 and RI #129. The facility became aware of the allegation on 11/18/2025 at 5:00 PM.On 04/08/2026 at 9:30 AM Former Director of Nursing (FDON) #22 said she became aware of the alleged missing non controlled medication involving RI #12, RI #130, and RI #129 when the Former Administrator reported it to her. FDON #22 said as far as she was aware it was reported to the SA within two hours.On 04/08/2026 at 10:58 AM DCO # 2 said the allegation of misappropriation involving RI #12, RI #130, and RI #129 was reported to the administrator on 11/18/2025 at 5:00 PM and to the SA on 11/19/2025 at 7:14 PM. When asked if it was reported within required timeframes she said misappropriation was not serious bodily harm and would not need to be reported within the two hour time frame. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Based on interviews, record reviews and review of a facility policy titled Obtaining Patient/Resident Vital Signs, the facility failed to ensure a Licensed Practical Nurse (LPN) #12 obtained and documented Resident Identifier (RI) #122's temperature on 03/01/2025, when RI #122 experienced a change in his/her condition. Failure to obtain and document RI #122's temperature, an indicator of infection, did not meet the standard of care for a resident experiencing change in his/her condition and placed RI #122 at risk for decline in condition, including worsening respiratory status and infection.This failure affected RI #122, one of one resident reviewed for change of condition during the survey.This deficient practice were cited as a result of the investigation of facility reported incident/complaint/report number 447989.Findings Include:An undated facility policy titled Obtaining Patient/Resident Vital Signs included the following: . Policy:Vital Signs will be obtained at a minimum . change of condition. in accordance with standards of practice. RI #122 was admitted to the facility with an original admission date of 05/11/2007 and re-admission date of 02/12/2025 with diagnoses to include: Vascular Dementia, Pneumonia, Sepsis, Urinary Tract Infection, Adult Failure to Thrive and Elevated [NAME] Blood Count.RI #122's Quarterly Minimum Data Set with an Assessment Reference Date of 01/23/2025 documented a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment.A review of RI #122's Progress Notes dated 03/01/2025 at 11:38 AM, revealed an SBAR (Situation Background Assessment Recommendation) - Change in Condition note that documented RESIDENT LETHARGIC WITH DIFFICULTY BREATHING O2 SAT 87, LUNGS CONGESTED BILATERALLY. BLOOD PRESSURE 114/92, 148, 24. The progress note was written by RN #11 and there was no documentation that RI #122's temperature had been taken.RI #122's hospital History and Physical Note for date of service 03/01/2025 documented RI #122's oral temperature was 104.4 degrees Fahrenheit dated 03/01/2025 at 12:48 PM and 103.6 degrees Fahrenheit dated 03/01/2025 at 3:20 PM. On 04/06/2026 at 4:55 PM the surveyor conducted an interview with Licensed Practice Nurse (LPN) #12 regarding care and treatment of RI #122. LPN #12 said that she took RI #122's vital signs on 03/01/2025. When asked did she document the vital signs that day, she said no, and that she had the vital signs written on a piece of paper and gave them to Registered Nurse (RN) #11 to document.On 04/07/2026 at 4:41 PM the surveyor conducted an interview with Registered Nurse (RN) #11. The RN #11 said vital signs included blood pressure, heart rate, respiration, temperature and oxygen saturation. The surveyor asked RN #11 who charted the vitals for RI #122 on 03/01/2025. RN #11 said she charted the vitals that were given to her on a piece of paper, and the vital signs were used to obtain the overall stability of RI #122. RN #11 further stated obtaining a temperature was part of the standard of care and failing to obtain a temperature could delay treatment. RN #11 said the nurses taking the vital signs were responsible for documenting the vital signs. RN #11 said the concern of not obtaining a full set of vitals, including the temperature, would not meet the standards of care for a resident with a change in their condition.On 04/07/2026 at 9:45 AM the surveyor conducted an interview with the Assistant Director of Nursing (ADON). When asked, according to facility's policy, what was the frequency for assessing vital sign, the ADON said when there was a change of condition with the resident. The ADON said the standard of care for obtaining and documenting vital signs was after a resident's assessment showed there was a change of condition with the resident. When the ADON was asked about the concern of not obtaining vital signs, including the temperature, on a resident with a history of pneumonia, she said failure to obtain all vital signs would not meet the standard of care.On 04/07/2026 at 11:50 AM the surveyor conducted an interview with the Nurse Practitioner (NP). The NP said her expectations for obtaining vital signs, including temperature, would be when there was a change of condition with the resident.On 04/09/2026 at 4:33 PM the surveyor conducted an interview with the Medical Director (MD). The MD said she would like to be notified of any change in vital signs, including temperature, and/or change of condition with the resident. The MD further stated that not obtaining vital signs on a<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident with a history of pneumonia, could have had worsening symptoms without staff recognizing a change in the resident's condition. |