STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445260	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Oak Ridge	100 Elmhurst Dr Oak Ridge, TN 37830

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003 Based on facility policy review, observations, and interviews the facility failed to provide a homelike environment for 1 resident room (#512) of 7 resident rooms observed for homelike conditions and failed to prevent foul odors for 1 hallway of 5 hallways observed. The findings include: Review of the facility's policy titled, Resident's Rights and Quality of Life, dated 5/1/2012, revealed .It is the policy .that all residents have the right to a dignified existence .A resident has the right .To receive services in a facility environment that is safe, clean, and comfortable . Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Paraplegia, Pressure Ulcer of Left Heel, Severe Protein-Calorie Malnutrition, and Muscle Weakness. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #40 scored 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of a facility Census List revealed Resident #40 transferred from room [ROOM NUMBER] to room [ROOM NUMBER] on 7/24/2024. During an observation of room [ROOM NUMBER] B and interview on 8/13/2024 at 10:36 AM, revealed damaged and peeling dry wall, with an approximately 6-inch x 10.5-inch hole, located behind the bed, and to the right side of the head of the bed. Resident #40 stated the hole in the wall behind his bed was present when he transferred to the room. Resident #40 stated environmental services staff had brought a maintenance staff to his room and showed him the wall .a couple of weeks ago . During a second observation of room [ROOM NUMBER] and interview on 8/15/2024 at 9:40 AM, revealed additional areas of damaged dry wall, above the base board, on the left side of the bed. Resident #40 stated the hole, on the left side of his bed was present when he transferred to the room. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and observation of room [ROOM NUMBER] B on 8/15/2024 at 9:50 AM, with the Administrator and Corporate Regional [NAME] President, the Administrator confirmed the dry wall behind the resident's bed was damaged and confirmed the facility had not provided a homelike environment for Resident #40. During observations of the 600 Wing between room [ROOM NUMBER] and the Wound Care Office on 8/19/2024 at 9:32 AM; at 10:38 AM; and 2:00 PM revealed the presence of a strong, foul odor persisted throughout the observations and was unable to be identified. During an interview and observation with the Director of Nursing (DON) and Administrator while standing in the impacted area of the 600 Wing on 8/19/2024 at 2:15 PM revealed the foul smells persisted. Both the DON and Administrator confirmed the facility had failed to maintain a homelike environment on the 600 wing when fould odors persisted through the wing.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534 Based on facility policy review, medical record review, facility investigation documentation review, observation, and interview, the facility failed to protect the residents' right to be free from physical abuse by a resident for 2 residents (Resident #1 and #7) and verbal abuse by a resident for 2 residents (Resident #7, and #9) of 22 residents reviewed for abuse. The findings include: Review of a facility policy titled, Abuse, Neglect, Misappropriation, Exploitation Policy, dated January 2019, revealed .Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Physical Abuse: includes, but is not limited to, hitting, slapping, punching, biting and kicking .Verbal abuse . includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend . Review of the medical record revealed Resident #1 was admitted on [DATE], with diagnoses including Metabolic Encephalopathy, Altered Mental Status, Dementia without Behavioral Disturbance, and Cognitive Communication Deficit. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact, with no noted behaviors during the assessment period. Review of the Nurse's Note for Resident #1 dated 6/11/2024 at 10:45 AM, revealed .this nurse informed by CNA [Certified Nursing Assistant] [F] that another resident [Resident #3] had informed her she seen another resident [Resident #2] enter [Resident #1's] room and then she heard [Resident #1] yelling 'don't you hit me!' . [Resident #1] then told this nurse a man [Resident #2] came into his room had hit him in the face .Both [Resident #1] and the other witness [Resident #3] identified the same man [Resident #3] as the one that came into his room . Review of the medical record revealed Resident #2 was admitted to the facility 6/10/2024 at 6:40 PM, and discharged on [DATE] at 12:52 PM, with diagnoses including Insomnia, Depression, Psychosis, Metabolic Encephalopathy, Altered Mental Status, and Dementia without Behavioral Disturbance. Review of a discharge MDS assessment for Resident #2 dated 6/11/2024, revealed discharge assessment-return anticipated. A BIMS assessment was not completed. Behaviors of physical symptoms directed towards others and verbal symptoms directed toward others occurred 1 to 3 days during the assessment period. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse's Note for Resident #2 dated 6/11/2024 at 7:41 PM, revealed .at approximately 10:30 AM, res [resident] went into another residents' room . [Resident #2] left the room after this incident. [Resident #2] was placed on 1 on 1 until his departure .NP [Nurse Practitioner] was contacted and gave order to send res. out to [hospital] for psych [psychiatric] eval [evaluation] . Review of the facility investigation dated 6/11/2024, revealed Resident #3 (now discharged) witnessed Resident #2 go into Resident #1's room and slam the door, she heard someone say, What are you doing in here? and Don't hit me. She then witnessed Resident #2 come out of the room. She reported this to CNA F who went and spoke to Resident #1. Slight redness was present on Resident #1's cheeks. Resident #1 confirmed he was okay and was not afraid. Resident #2 was placed on continuous 1 to 1 staff observation. Both residents' physician was notified, and an order was received to send Resident #2 to the hospital for evaluation and he was admitted . Resident #2 was confused and when asked why he had struck Resident #1 he replied, I thought he stole me. When asked why he went into Resident #1's room he stated, that was my room. I want to leave. Mental health services were notified for follow up with Resident #1. Review of a facility documented interview with Resident #3 dated 6/11/2024, revealed .[Resident #3] states she observed [Resident #2] enter [Resident #1's] room. She then heard someone say, 'What are you doing? Get the hell out of my room.' She then heard someone say, 'don't hit me.' She stated that [Resident #2] slammed the door and walked out of the room . During an interview on 8/12/2024 at 11:10 AM, the Rehabilitaion Director . stated I was here that day [6/11/2024], but I did not witness the incident [Resident #1] came to therapy after the incident .He [Resident #1] did understand that the other resident [Resident #2] was confused and was not in his right mind .he [Resident #1] wasn't tearful, he did want to talk about the incident, but he was not emotional .he wasn't weepy he wasn't withdrawn. He was not afraid . The Rehabilitaion Director stated there were not visible signs of injury to Resident #1 and the resident did not verbalize any pain from the incident. During an observation and interview on 8/12/2024 at 11:25 AM, of Resident #1, in his room, showed the resident lying on the bed he was awake, alert, with no signs of distress.Resident #1 stated .I'm doing alright . When asked about the incident he stated .he [Resident #2] knocked on my door like the staff do .I was standing over there he came in and said what are you doing with my wife in your bed. I said I don't have your wife, no one is in the bed . Resident #1 stated Resident #2 struck out at both of his cheeks.no it didn't hurt, I just couldn't figure out why he thought I had his wife in my bed .he didn't draw blood or anything like that, and like I said it didn't hurt. It kind of stunned me that he had hit me .no I wasn't scared, and I am not scared now . he wasn't in his right mind .there was a lot of people coming in and out of here to check on me . During an interview on 8/13/2024 at 11:45 AM, the Certified Occupational Therapy Assistant stated .I saw him [Resident #1] in the afternoon somewhere between 1:00 PM and 2:00 PM, (incident occurred approximately 2 1/2 hours prior) and there was no evidence that he had been smacked on his face. There was no redness, no bruising, no abrasions .he did talk about the incident, he just expressed what had happened .he wasn't distraught, fearful, or emotionally upset, he simply told me what happened . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/2024 at 2:20 PM, the Previous Administrator stated basically Resident #2 was confused and didn't know where his room was. He entered [Resident #1's] room thinking it was his own and may have popped [slapped] [Resident #1] twice once one each cheek. There wasn't any lasting redness or bruising .he confirmed to me that the gentleman did strike him, so I did feel like it was willful intent and abuse had occurred. He did not report being afraid, and I saw no signs of fear, tearfulness or being withdrawn. During an interview on 8/14/2024 at 12:15 PM, Licensed Practical Nurse (LPN) U stated .[CNA I] came and told me that [Resident #3] reported to her she had seen a resident enter [Resident #1's] room and heard [Resident #1] say don't you hit me .No [Resident #3] did not witness the altercation .there was no witnesses . I immediately went to the room, [Resident #2] had already left the room .I spoke to [Resident #1] and he told me that a man [Resident #2] had come in his room and hit him in the face 2 times .his face is always a little red .he didn't have any abrasions or bruising .[Resident #1] didn't understand why the resident had come in his room and hit him .he wasn't tearful or crying, he wasn't withdrawn .I did a head to toe assessment on [Resident #1] and there were no injuries .the slight redness was gone in just a very few minutes less than 30 minutes, and the areas never bruised .when I checked on him at the time and within minutes he was calm, he wasn't scared, tearful or anything .we took [Resident #2] to the day room and a CNA stayed with him 1 on 1 until the ambulance transported him to the hospital .[Resident #2] .was confused, I don't think he knew what he had done . During an interview on 8/14/2024 at 12:35 PM, CNA I stated .I went in [Resident #3's] room to get her lunch tray. She told me that the man across the hall was saying don't hit me .she didn't see the altercation, she just heard what [Resident #1] said .I went in the room and checked on [Resident #1] and no one was in the room with him .I asked [Resident #1] if anyone had been in his room and he said yes that a man had come in his room and hit him in the face .he was barely red in the face under both eyes .I went to the desk and got the nurse .[Resident #2] .had just admitted the evening before and he was really confused .I had not seen any aggressive behaviors from him . During an interview on 8/14/2024 at 3:25 PM, the Medical Director stated .[Resident #2] was very confused and moody .he was here for a very short time and was sent out .[Resident #1] didn't have any bruising or fractures .he has mild dementia .He had no pain, no headaches, no physical harm .emotionally because of his demeanor he is forgetful and a forgiving guy he forgot about it very quickly .he remains social .in my professional opinion he did not suffer any physical harm or emotional harm . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses Dementia with Behavioral Disturbance, Psychosis, Chronic Kidney Disease, Sequela of Cerebral Infraction, Schizoaffective Disorder, Anxiety Disorder, and Major Depressive Disorder. Review of the Nurse's Notes for Resident #7 dated 1/9/2024 at 8:23 PM, revealed .Resident .was the recipient of verbal and physical aggression this evening from another resident [Resident #8] .residents were separated, and safety was ensured. Resident was interviewed a few minutes after event by Administrator and was unable to recall the event. She shows no signs of fear . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility investigation dated 1/9/2024, revealed the event was witnessed by CNA S. CNA S reported the allegation of verbal and physical abuse to LPN L. There were no physical injuries to Resident #7 or Resident #9. Resident #7 reported she did feel safe and was unable to recall the incident. The facility facilitated a room change since her roommate [Resident #8] is also the aggressor. The Medical Director was the physician for all 3 residents involved and was notified. Resident #8 was placed on observation by the staff. She was not to have a roommate on 1/9/2024 and was referred for mental health services. Residents #7, #8, and #9 were sitting in the dayroom prior to supper meal delivery. Staff members were also nearby but were unable to determine what the residents' conversations were about. Resident #9 became louder in her conversation and Resident #8 told her to shut up. Resident #8 began to wheel herself out of the dayroom as staff responded to the situation. However, Resident #8 turned around and told Resident #7 to shut up and struck Resident #7's hand with her own closed fist. Review of the Physician's Progress Note for Resident #7 dated 1/10/2024 at 3:06 PM, revealed .[Resident #7's] hand was smacked yesterday [1/9/2024] by another resident [Resident #8]. Residents were immediately separated and pt.'s [patient's] hand showed no sign of injury. Pt. seen this AM, she is in bed, now in new room. She is alert and in good humor this AM. Oriented to name only, no recall of events, did let me look at both arms and hands-no bruising, swelling, redness noted. She denies any pain .No changes required . Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses included Dementia with behavioral Disturbance, Psychosis, Major Depressive Disorder, Anxiety Disorder, and Senile Degeneration of Brain, Cerebellar Ataxia. Review of a quarterly MDS assessment dated [DATE], revealed Resident #8 did not have a BIMS or a staff assessment completed. Review of the Nurse's Note for Resident #8 dated 1/9/2024 at 8:15 PM, revealed .this resident exhibited aggressive verbal and physical behavior toward others this evening. There was no injury to anyone. Resident does not recall the event minutes afterward. Resident is under staff observation for her own safety and the safety of others at this time . Review of the Physician's Note for Resident #8 dated 1/10/2024, revealed .requested to see Pt. with incident yesterday of smacking other resident [Resident #7] on the hand. Staff report other resident [Resident #9] sitting near her and told her to 'shut up.' There was no physical injury noted to either resident at the time. Residents were separated. Pt. seen this AM. She is alert, has no recall of the incident, 'I don't remember that. ' She is calm with no indication of aggressive behaviors now. She has been separated from the other residents. I see no medication changes required today. Pt. with known history of dementia. I don't think she recalls the incident and does not have the insight or judgement to discuss it further . Review of a quarterly MDS assessment dated [DATE], revealed Resident #8 scored a 9 on the BIMS assessment which indicated the resident had moderately cognitive impairment. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], and discharged on [DATE], with diagnoses included Dementia with Behavioral Disturbance, Anxiety Disorder, Severe Protein-Calorie Malnutrition, and Vertigo. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurse's Notes for Resident #9 dated 1/9/2024 at 8:20 PM, revealed .Resident #9 was the recipient of verbal aggression from another resident this evening. Residents were separated and safety ensured. [Resident #9] was interviewed but was unable to recall the event just a few minutes later. Resident displays no sign of fear . During an interview on 8/12/2024 at 10:55 AM, Resident #7 stated when asked how she was I'm just [NAME]. When asked about the incident she stated do what? I am not sure what you are talking about . Additional details about the incident were given to the resident but the resident had no recall of anyone mistreating her, yelling at her, or smacking her hand. During an interview on 8/12/2024 at 11:05 AM, Resident #8 stated when asked about the incident I don't remember that .I don't remember yelling or smacking anyone .I don't know what you are talking about . During an interview on 8/12/2024 at 1:40 PM, CNA T stated .it was at the end of the shift [Resident #8] and[Resident #7] were roommates both were very confused. They were in the day room the television was loud. [Resident #7] was really confused, and she kept telling [Resident 8] she was going to call the police on her. There are two tables in there and there were several residents in there. I didn't hear her [Resident #8] tell [Resident #9] to shut up, [Resident #8] was starting to leave the table then backed up, [Resident #7] kept saying she was going to call the police, then [Resident #8] just popped [Resident #9] on the hand it wasn't hard, her hand wasn't red at all. [Resident #9] wasn't upset she wasn't crying or tearful, she didn't yell out when she got smacked she didn't act like it even phased her .we pulled [Resident #8] out of the dining room . there was no emotion from [Resident #9] .that made me think anything had happened to her .[Resident #8] and [Resident #7] both were moved to increase the space between them. [Resident #7] .she is sociable, not withdrawn, not fearful, [Resident #8] .hasn't changed any. Neither of them remembered the incident almost immediately. The Administrator .talked to all 3 of the residents and none of them remembered .[Resident #8] did pop her [Resident #7's] hand on purpose .to get her to stop whatever it was she was doing .when we realized she [Resident #8] wasn't going to leave the day room, we started toward them, but we couldn't get to her before she popped [Resident #7] on the hand . During an interview on 8/12/2024 at 1:55 PM, CNA J, stated .several residents were in the day room .I didn't hear [Resident #8] tell [Resident #9] to shut up .I heard [Resident #7] and [Resident #8] talking .before I could get to them, I saw [Resident #8] smack [Resident #7] on the top of the hand. It wasn't hard it was like you would smack a small child's hand .We separated them and [CNA T] took [Resident #8] out of the day room .[Resident #7] wasn't crying or scared or anything like that .she didn't yell or jerk her hand when she was hit, it wasn't a hard hit . During an interview on 8/12/2024 at 4:30 PM, LPN L stated .the CNAs were in the day room .I heard a commotion in the day room, I told the CNAs to separate the residents, and I told the nurse to call the Administrator. [Resident #7] did not have any redness, swelling or bruising to her hand .neither of the 3 residents were upset, no one was crying or tearful, no one was acting fearful . During an interview on 8/13/2024 at 2:20 PM, the previous Administrator stated .the 3 residents were setting at the dining room table .[Resident #8] does have dementia, but I do believe there was intent there .we did substantiate abuse had occurred .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003 Based on facility policy review, medical record review, facility investigation documentation review, and interview, the facility failed to report an allegation of sexual assault to the State Agency within 2 hours as required, for 1 resident (Resident #10) of 22 resident's reviewed for abuse. The findings include: Review of the facility policy titled, Abuse, Neglect, Misappropriation, Exploitation Policy, dated 1/2019, revealed .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 .Abuse . includes .sexual abuse .Nonconsensual sexual contact of any type with a resident/patient . Reporting/Response .Alleged violations/violations will be reported to the Administrator, designee immediately. Immediately reporting all alleged violations to the Administrator, designee, state agency, adult protective services and to all other required agencies .with specified timeframes . Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Parkinson's Disease with Dyskinesia, Bipolar Disorder, Major Depressive Disorder, Anxiety Disorder, and Schizoaffective Disorder. Review of a Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 scored 11 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. The resident wandered daily during the assessment period. Review of the physician's notes for Resident #10 dated 1/26/2024 at 11:46 AM, revealed .[Resident #10] complained sexual assault happening when she went out over a weekend .says a staff member here .[took] to their house, then led to a shed where she was assaulted, thinks this is was three weeks ago but no evidence she was out of building in looking at nurse notes, she did go to church on wed night .same scenario on tv on a crime show was playing while he [Administrator] talked to her in room [Resident #10's room] this problem is complicated by schizophrenia, she did nto [not] think she was in her own room .There is no evidence the assault happened but she believes it has and is distressed over this . Review of facility investigation documentation revealed the previous Director of Nursing (DON) and previous Administrator became aware of Resident #10's allegation of sexual assault on 1/28/2024 at 4:30 PM (2 days after reported to the resident's physician). Resident #10 .reported to her physician that about 3 weeks ago someone had taken her from the center to a shed and sexually assaulted her . During an interview on 8/14/2024 at 2:50 PM, the Medical Director stated Resident #10 reported she was taken from the facility, was taken to a shed and was sexually abused.in her [Resident #10] mind she was taken to a shed and was sexually abused . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/19/2024 at 1:30 PM, the Administrator stated allegations of abuse were to be reported to the State Agency within 2 hours of the allegation. The Administrator confirmed Resident #10's allegation of sexual assault was not reported to the State Agency within 2 hours as required and confirmed the facility failed to follow the facility's abuse policy related to reporting an allegation of abuse for Resident #10. During an interview on 8/19/2024 at 10:55 AM, the Medical Director stated she notified someone of Resident #10's allegation immediately, and documented what the resident reported in the resident's medical record on the same day the allegation was made (Physician note was dated 1/26/2024 at 11:46 AM). During a telephone interview on 8/19/2024 at 2:02 PM, the previous Administrator stated .I do remember talking to [Resident #10] on multiple times .3 or 4 different times .she had not given me anything of an allegation of abuse, but when she did, I reported it to the state . When asked why he started questioning Resident #10, the previous Administrator stated .I believe someone let me know that her confusion was increasing .I believe that was what started it all .I do know she has reported this similar allegation before . When asked if he recalled the resident's physician, the DON, or a staff member reporting the allegation made by Resident #10, the previous Administrator stated .No .No, I don't remember .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534 Based on facility document review, Resident Assessment Instrument (RAI) Manual 3.0 review, medical record review, and interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 resident (Resident #8) of 13 residents reviewed. The findings include: Review of an undated, facility document titled, RN [Registered Nurse] Nurse Assessment Coordinator, revealed .supervises, coordinates and facilitates the timely and accurate completion of the RAI process . ensures accurate and timely MDS assessments according to state and federal regulations . Review of the RAI Manual 3.0 dated 10/1/2023, revealed .the assessment [MDS] accurately reflects the resident's status . Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses included Dementia with behavioral Disturbance, Psychosis, Major Depressive Disorder, Anxiety Disorder, and Senile Degermation of Brain, Cerebellar Ataxia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 did not have a Brief Interview for Mental Status (BIMS) or a staff assessment completed. During an interview on 8/19/2024 at 3:00 PM, Registered Nurse (RN) V/MDS Coordinator confirmed the MDS assessment dated [DATE], for Resident #8 did not have a BIMS assessment or staff assessment completed for mental status. She stated .the computer generates which sections should be completed and on a quarterly MDS. C section for mental status should have been completed and it was not .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445260	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Diversicare of Oak Ridge	100 Elmhurst Dr Oak Ridge, TN 37830

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405 Based on facility policy review, medical record review, and interview, the facility failed to ensure professional standards of practice were followed when transportaion was not provided to outpatient scheduled appointments for 2 residents (Resident #25 and Resident #34) of 6 residents reviewed for transportation needs. The finding include: Review of the facility policy titled, Standards of Practice, undated, revealed .The expectation set forth by . management is that nurses comply with current standards of practice .this includes following orders for outside appointments/referrals .center can arrange transportation if required . Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Atherosclerotic Heart Disease, Foot Drop, and Muscle Weakness. Continued review revealed the resident discharged out of the facility with family on 5/13/2024. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #25 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of hospital discharge documentation for Resident #25 dated 4/30/3034, revealed the resident's post discharge orders included .scheduled appointments: office visit 5/8/2024 at 2:20 PM .[Cardiology Physician's Group] . Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Hypertension, Chronic Obstructive Pulmonary Disease, and Chronic Kidney Disease. Review of an admission MDS assessment dated [DATE], revealed Resident #34 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of hospital discharge documentation for Resident #34 dated 7/25/2024, revealed the resident's post discharge orders included .scheduled appointments: office visit 8/5/2024 at 1:00 PM .[a Brain and Spine Center] . During an interview on 8/13/2024 at 8:55 AM, Resident #34 stated she had to cancel an appointment due to the lack of transportation. Continued interview revealed the facility told the resident after she had canceled the appointment, the facility could have provided the transportation. Further interview revealed, the resident was not told and was not aware the facility could have provided the transportation to the outpatient appointment. Further interview revealed .I would have gone [to the Brain and Spine Center] if I knew they [facility] provided transportation . During an interview on 8/13/2024 at 10:15 AM, the Transportation Director (TD) stated she was not aware of the missed appointments for Resident #25 or Resident #34. Continued review of the TD's transportation log with the TD revealed no documentation of any scheduled or missed appointments for Resident #25 or Resident #34. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and medical record review on 8/13/2024 at 2:18 PM, the Director of Nursing (DON) stated there was no documentation in the resident chart which indicated Resident #25 or Resident #34 had gone to the scheduled appointments. The DON confirmed the facility failed to ensure transportation was provided for the residents to the scheduled outpatient appointments. During an interview and medical record review on 8/14/2024 at 12:20 PM, the Medical Director stated the facility could improve on the follow up of outside appointments related to scheduling and tranportation. Continued interview revealed Resident #25 and Resident #34 had not had any negative outcome or adverse events due to the missed appointments.