

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445310	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Diversicare of Copper Basin		STREET ADDRESS, CITY, STATE, ZIP CODE 166 Industrial Drive Po Box 518 Copperhill, TN 37317	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to protect 2 residents (Resident #3 and Resident #42) from physical abuse during resident-to-resident altercations of 3 residents reviewed for abuse. Review of the facility's policy Abuse, Neglect, Misappropriation, Exploitation, dated January 2019, revealed .Purpose: To prohibit and prevent abuse .Physical Abuse .hitting, slapping, punching . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia with Psychotic Disturbance, Generalized Anxiety Disorder, and Restlessness/Agitation. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including Dementia and Generalized Muscle Weakness. Review of a quarterly MDS assessment dated [DATE], revealed Resident #14 scored a 1 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan dated 5/11/2026, revealed Resident #14 .have behaviors which include: Verbally abusive, physically abusive, rejection of care .will calm down with staff intervention .behavior will stop with staff intervention .Let .physician know if .behaviors are interfering with .daily living . Review of a General Note dated 5/30/2026, revealed .Resident [#3] reported to staff that he was having words with his roommate [Resident #14] when the roommate grabbed his left wrist. He grabbed .my wrist. Residents were separated, skin assessment completed with no bruising, redness or deformity noted to left wrist., x-ray of left wrist ordered .Other resident [Resident #14] was moved . Review of a Radiology Report dated 6/1/2026, for Resident #3 revealed .wrist .left .results: no acute fracture or dislocation . Review of the Physician's Orders for Resident #14 dated 7/1/2026, revealed . Carbamazepine [medication to treat agitation] 100 mg [milligrams] one time a day .AM [morning] and 200 mg one time a day .HS [hour of sleep] .Lorazepam [medication to treat anxiety] 0.5 mg every 8 hours as needed . During an interview on 7/29/2026 at 3:23 PM, Resident #3 stated there had been no prior incidents with Resident #14 prior to 5/30/2026 and stated he did not want to discuss the incident and stated he Resident #14 did not hurt him. During an interview on 7/29/2026 at 4:48 PM, Certified Nursing Assistant (CNA) D stated he provided care for Residents #3 and #14 routinely, worked on 5/30/2026, and was assigned to care for Residents #3 and #14 (roommates). CNA D also stated he had not observed any agitation or behaviors from Resident #3 or #14 during the shift (7:00 AM- 7:00 PM). Licensed Practical Nurse (LPN) C informed CNA D an alleged altercation had taken place where Resident #14 grabbed Resident #3's wrist (unable to recall which wrist) and possibly twisted it. Certified Nursing Assistant (CNA) D was instructed to assess Resident #3's wrist and hand for any (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signs of injury such as swelling, bruising, or pain. Resident #3 did not complain of pain and did not have any signs of injury on 5/30/2026. CNA D stated he was assigned to Resident #3 on 5/31/2026 (day after the alleged incident), CNA D continued to assess the resident's wrist and hand for signs of injury, the resident did not complain of pain, and there were no signs of injury. Further interview revealed CNA D had not observed Resident #14 having any physical altercations with any other resident prior to 5/30/2026. During an interview on 7/29/2026 at 4:55 PM, LPN C stated she cared for Residents #3 and #14 routinely, worked on 5/30/2026 (7:00 AM-7:00 PM), and was assigned to care for Residents #3 and #14. LPN C also stated she did not observe an altercation between the residents during the shift (7:00 AM-7:00 PM). Further interview revealed LPN F had informed LPN C of an alleged altercation where Resident #14 grabbed Resident #3's left wrist and twisted it. Resident #14 was immediately placed on 1:1 observation and relocated to a private room. Resident #3's wrist, arm, and hand was assessed for injury and there was no injury. Resident #3 denied any pain and informed LPN C he was fine. Continued interview revealed LPN C worked on 5/31/2026 and continued to assess Resident #3's left wrist for signs of injury. Resident #3 did not complain of pain and there were no signs of injury. LPN C had not observed Resident #14 having any physical altercations with any other resident prior to 5/30/2026. During an interview on 7/29/2026 at 5:00 PM, CNA E stated she worked on 5/30/2026 (7:00 AM-7:00 PM), was assigned to work on the hallway where Resident #3 and #14 resided, was not assigned to care for the residents directly, but had assisted with Resident #14's care. CNA E stated she did not observe any agitation or behaviors from Resident #3 or #14 throughout the shift and did not witness Resident #14 grab Resident #3's arm. Further interview revealed CNA E overheard Resident #3 tell LPN C Resident #14 .pulled his hand . LPN C asked Resident #3 if he was hurt and the resident stated .no he [Resident #14] is just an [explicative] . CNA E was instructed to .keep an eye . on Resident #3's wrist (unable to recall which wrist) for signs of injury such as swelling, pain, or bruising, there were no signs of injury, and the resident did not complain of pain. CNA E stated she worked on 5/31/2026 and worked the same hallway as she did on 5/30/2026. CNA E continued to observe Resident #3 for signs of injury, there were none, and the resident did not complain of any pain. Further interview revealed CNA E had not observed Resident #14 having any physical altercations with any other resident prior to 5/30/2026. During an interview on 7/29/2026 at 5:00 PM, LPN F stated she worked on 5/30/2026 (7:00 AM-7:00 PM), was assigned to work on the hallway where Resident #3 and #14 resided but was not assigned to care for the residents directly. LPN F also stated Resident #3 exited the therapy gym after receiving therapy services and reported Resident #14 had twisted his left wrist (did not give an exact time). LPN F reported the allegation to Resident #3's nurse (LPN C), the resident was assessed for injury, there were no signs of injury, and the resident denied pain. Resident #14 was placed on 1:1 supervision, moved to a private room, and the Director of Nursing (DON) and Administrator were notified immediately of the allegation. Further interview revealed LPN F had not observed Resident #14 having any physical altercations with any other resident prior to 5/30/2026. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnosis including Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side. Review of a quarterly MDS assessment dated [DATE], revealed Resident #42 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of a General Note dated 7/2/2026 .Resident [Resident #42] reported roommate [Resident #14] aggressive with him both verbally and physically. [Resident #42] reported and staff overheard that his roommate [Resident #14] came over to his side of curtain and told him he needed to get out of here. [Resident #42] told roommate [Resident #14] that he needed to get out of his part of the room and that's when his roommate [Resident #14] (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slapped me -on the arm and then across my face. He [Resident #42] indicated that it was to his right arm and right side of face. At the time of exam, no injuries noted. [Resident #42] was asked if he would like to go to the hospital for a full evaluation, and he declined stating he [Resident #14] didn't hit me that hard, I'm ok . During an interview on 7/29/2026 at 10:40 AM, CNA I stated she was picking up dinner trays and overheard Resident #14 and Resident #42 arguing in their room. Resident #42 stated to CNA I that Resident #14 had slapped him on the arm and face. CNA I removed Resident #14 from the room and reported the altercation to the charge nurse which was the DON that evening. During an interview on 7/29/2026 at 11:03 AM, the DON stated he did not witness the altercation between Residents #42 and #14 but was informed by CNA I what had occurred. The DON stated Resident #14 was removed immediately from the room. Resident #42 was assessed for injuries, and none were observed. Resident #14 was sent to the emergency room, returned within a few hours, and was placed in a private room. The DON also stated Resident #42 stated he was not hurt. During an interview on 7/29/2026 at 6:02 PM, the Social Service Director/Admissions Coordinator (SSD/AC) stated Resident #3 reported Resident #14 had grabbed or twisted his arm on 5/30/2026. Resident #14 was placed on 1:1 supervision, moved to a private room, and evaluated by psychiatric services for an increase in behaviors. Further interview revealed Resident #14 remained in the private room until his moods and behaviors stabilized. Resident #14's mood and behaviors were stabilized after medication changes and was moved in with Resident #42 (unsure of exact date) approximately 1 month after the 5/30/2026 allegation. Continued interview revealed on 7/2/2026 Resident #42 reported Resident #14 slapped him. Resident #14 was placed on 1:1 supervision, transported to the emergency room for evaluation, returned to the facility within a few hours, placed in a private room, and remained in a private room currently. The SSD/AC stated Resident #14 had not had any further incidents since the incident on 7/2/2026 with Resident #42. During an interview on 7/29/2026 at 7:22 PM, the DON stated LPN F reported an allegation of abuse on 5/30/2026. Resident #3 informed LPN F Resident #14 grabbed and twisted his left arm and the alleged altercation was not witnessed. Resident #14 was placed on 1:1 supervision, moved to a private room, and evaluated by psychiatric services for an increase in behaviors. The DON assessed Resident #3's left wrist, arm, hand, and fingers for injury and there were no visible injuries. Resident #3 was offered to be evaluated at the emergency room and refused. Further interview revealed Resident #14 remained in the private room until his moods and behaviors stabilized. Resident #14's mood and behaviors were stabilized after medication changes and the resident moved in with Resident #42 (unsure of exact date) approximately 1 month after the 5/30/2026 incident. There were no reported altercations which involved Resident #14 prior to the 5/30/2026 incident with Resident #3. Continued interview revealed on 7/2/2026, Resident #42 reported Resident #14 slapped him. Resident #14 was placed on 1:1 supervision, transported to the emergency room for evaluation, returned to the facility within a few hours, placed in a private room, and remained in a private room currently. The DON stated Resident #3 had not had any further incidents since the incident on 7/2/2026 with Resident #42. During a telephone interview on 7/29/2026 at 6:54 PM, the Behavioral Health Physician Assistant (BHPA) stated she was familiar with Resident #14 and aware of the altercation on 5/30/2026 which involved Resident #3. The BHPA assessed Resident #14 after the incident had occurred and ordered the resident a mood stabilizer and had increased the dose of medication until the resident's moods and behaviors stabilized. Further interview revealed Resident #14 was placed with another roommate (Resident #42) and Resident #14 slapped Resident #42. Resident #14 was placed in a private room and remains in a private room currently. Continued interview revealed there had been no further incidents involving Resident #14 and stated the facility could not have foreseen the 2nd incident due to the resident being stabilized and no further incidents of agitation or aggression.		