

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  015119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/15/2024
NAME OF PROVIDER OR SUPPLIER  Arabella Health and Wellness of Selma		STREET ADDRESS, CITY, STATE, ZIP CODE  11 Bell Road Selma, AL 36701	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33739</p> <p>Based on observations, interviews, and the facility policy titled, Safe and Homelike Environment, the facility failed to ensure two of six shower rooms on the South unit in the facility were free of soap build up on the walls and dark coloring on the floors.</p> <p>This affected Resident Identifier (RI) #108, and two of 11 shower rooms in the facility; however, the deficient practice had the potential to affect all 60 residents residing on the South unit who used the shower rooms.</p> <p>This deficient practice was cited as a result of the investigation of complaint/report number AL00048274.</p> <p>The facility further failed to ensure the left arm rest on RI #73's wheelchair (WC) was not torn.</p> <p>This affected RI #73, one of one resident observed with a torn WC armrest.</p> <p>Findings Include:</p> <p>Review of an undated facility policy titled, Safe and Homelike Environment, documented:</p> <p>Policy: In accordance with resident rights the facility will provide a safe, clean, comfortable and homelike environment, .</p> <p>Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to equipment used in completion of the activities of daily living.</p> <p>On 07/10/2024 at 8:25 AM, the shower rooms were observed, two of the shower rooms on South unit were found with stains, and dried soap on the walls and floors.</p> <p>RI #108 was admitted to the facility 03/02/2023.</p> <p>Review of RI #108's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date of 06/03/2024 indicated RI #108 had a Brief Interview for Mental Status score of 15 of 15 which indicated RI #108 was cognitively intact.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/10/2024 at 8:25 AM RI #108 complained shower rooms were dirty and an immediate observation was made of all the shower rooms on the South unit. The second shower room on the South unit was observed with the Administrator (ADM) and the Maintenance Director (MtD). The ADM was interviewed during the observation. The ADM said she saw dried soap and stained dark colored substance on floors of the second shower room of the South hall. The ADM said it was not homelike when the shower rooms were dirty. The surveyor and ADM observed the third shower room. The ADM said she saw stains on the walls and floor and there was an odor in the third shower room. She described what she observed in the third shower room as a dark coloring on tile and around the base of the floor. The ADM said it was not homelike. The ADM said the shower rooms should have been cleaned better.</p> <p>On 07/11/2024 at 6:11 PM, the MtD was interviewed as he was present during the observation of the shower rooms with the ADM. He said the facility had six shower rooms, and five tub rooms. He observed the shower rooms on the South unit and said they needed some work. The MtD said he observed soap build up and dark spots where water built up and dried. He said the shower rooms were not homelike.</p> <p>21055</p> <p>RI #73 was admitted to the facility on [DATE] and readmitted on [DATE].</p> <p>On 07/09/2024 at 12:59 PM, RI #73 was sitting up in a WC and the left arm rest on the WC was torn with a missing piece.</p> <p>On 07/10/2024 at 6:45 PM, RI #73's arm rest remained torn with a missing piece.</p> <p>On 07/11/2024 at 7:38 AM, the left arm rest remained the same.</p> <p>On 07/12/2024 at 8:19 AM, RI #73's left arm rest on the WC remained with the torn area.</p> <p>On 07/14/2024 at 1:14 PM, the left arm rest on RI #73's WC remained in the same condition.</p> <p>On 07/14/2024 at 1:27 PM, the ADM #20 was shown RI #73's left arm rest and asked, how should the arm rest on the resident's WC look. ADM #20 said it should not be torn and tattered. When asked to describe RI #73's arm rest, ADM #20 said the arm rest was torn and worn and was not in good repair.</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48195</p> <p>Based on interviews, record review, group council meeting, and review of facility policy titled Resident and Family Grievances, the facility failed to ensure grievances filed by Resident Identifier (RI) #40 and RI #116 on 05/14/2024, 05/21/2024, and 05/30/2024 were resolved in a timely manner. Further, the facility failed to take prompt action to update complainants of progress towards a resolution.</p> <p>This deficient practice affected two of two residents sampled for grievances.</p> <p>Findings Include:</p> <p>A review of an undated policy titled Resident and Family Grievances revealed the following:</p> <p>Policy: It is the policy of this facility to support each resident's and family member's right to voice grievances .</p> <p>Definitions: Prompt efforts to resolve include . actively working toward resolution of that complaint/grievance .</p> <p>Procedure: .</p> <p>d. The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions on the form .</p> <p>e. The Grievance Official, or designee, will keep the resident appropriately apprised of the progress towards resolution of the grievances .</p> <p>RI #116 was admitted to the facility on [DATE].</p> <p>A review of RI #116 quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/17/2024 revealed RI #116's Brief Interview for Mental Status (BIMS) score was 15 of 15 which indicated intact cognition.</p> <p>RI #40 was readmitted to the facility on [DATE].</p> <p>RI #40's quarterly MDS assessment with an ARD of 06/20/2024 revealed a BIMS score of 9 of 15 which indicated moderate cognitive impairment.</p> <p>On 07/10/2024 at 3:05 PM a resident council meeting was held. The residents were asked if the facility responded timely with a resolution when grievances were filed. Residents voiced concerns regarding prompt action when grievances filed. RI #116 said he/she filed a grievance in May of 2024 regarding personal items damaged or missing and had not been informed of the progress toward a resolution.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/10/2024 at 4:36 PM, a review of the facility grievance book revealed RI #116 had unresolved grievances filed on 05/14/2024 and 05/21/2024 concerning damaged personal items. Further review of the forms revealed no documented action or efforts taken toward resolving the concern filed on either grievance.</p> <p>On 05/30/2024, RI #40's Responsible Party (RP) filed a grievance concerning RI #40's missing clothing items. Again, the form revealed no documented action or efforts taken towards resolving the complaint.</p> <p>On 07/10/2024 at 6:23 PM, an interview with the facility's Social Worker (SW) was conducted and revealed she was the Grievance Official. The SW said, when a grievance was filed, it was written up and submitted to the responsible department and follow up was done with the family and or resident regarding a satisfactory resolution. When asked what facility considered a prompt response time when following up with family or resident regarding grievance, she said, five days. When asked if July would be considered a prompt response time in following up with grievances filed in May, the SW said no. When asked why RI #116 had not been updated on the facilities efforts to resolve the complaint, the SW said the efforts should have been documented on the form.</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21055</p> <p>Based on interviews, record review, the facility policies titled, Social Media Use, Personal Cell Phones, Resident Photographs, and Abuse, Neglect and Exploitation, review of Facility Reported Incidents (FRIs) received by the Alabama State Survey Agency, review of the facility's investigative files, and review of an Incident/Offense Report, the facility failed to:</p> <p>1) ensure Resident Identifier (RI) #101 was free from mental and physical abuse perpetrated by staff at the facility.</p> <p>On 04/24/2024, Certified Nursing Assistant (CNA) #19 used her phone to record a video of CNA #18 physically and mentally abusing RI #101, who was in bed. In the recording CNA #18 taunted and laughed at RI #101 as she used aggressive force to pull up the resident's pants into the resident's perineum and buttocks. After CNA #18 pulled the resident's pants up, RI #101 pointed at CNA #18 and CNA #18 slapped RI #101's hand.</p> <p>The video was posted and circulated on social media showing what had been done to the resident and showing the resident's face. The video was sent anonymously by a non-staff member to the Social Worker/Director of Social Service (DSS) who reported the video to the Administrator (ADM) on 05/06/2024.</p> <p>It was determined the facility's noncompliance with one or more requirements of participation had cause, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 Freedom from Abuse, Neglect and Exploitation.</p> <p>On 07/15/2024 at 5:17 PM, the ADM and Director of Nursing (DON) were provided the IJ template and notified of the findings at the immediate jeopardy level and substandard quality of care in the area of Freedom From Abuse, Neglect, and Exploitation at F 600-Free from Abuse and Neglect.</p> <p>The IJ began on 04/24/2024 and continued until 05/14/2024 when the facility implemented corrective actions to correct the identified deficient practice and prevent reoccurrence.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00047806.</p> <p>The survey team applied the reasonable person concept to determine the severity of harm.</p> <p>2) Further the facility failed to protect RI #43's right to be free from physical abuse by RI #86. On 03/06/2024 RI #86 hit RI #43.</p> <p>This deficient practice affected RI #43, but this did not rise to the Immediate Jeopardy Level.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00047108.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3) Further the facility failed to protect RI #59's right to be free from physical abuse by RI #108. On 04/27/2024 RI #108 hit RI #59.</p> <p>This deficient practice affected RI #59, but this did not rise to the Immediate Jeopardy Level.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00047709.</p> <p>4) Further the facility failed to protect RI #95's right to be free from physical abuse by RI #48. On 05/06/2024 RI #48 slapped RI #95.</p> <p>This deficient practice affected RI #95, but this did not rise to the Immediate Jeopardy Level.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00047805.</p> <p>5) Further the facility failed to protect RI #43's right to be free from physical abuse by RI #123. On 06/12/2024 RI #123 spit at RI #43 and RI #43 hit RI #123.</p> <p>This deficient practice affected RI #43 and RI #123, but this did not rise to the Immediate Jeopardy Level.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00048127.</p> <p>6) Further the facility failed to protect RI #123's right to be free from physical abuse by RI #45. On 06/24/2024 RI #123 spit at RI #45 and RI #45 hit RI #123.</p> <p>This deficient practice affected RI #123 and RI #45, but this did not rise to the Immediate Jeopardy Level.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00048224.</p> <p>7) Further the facility failed to protect RI #45's right to be free from physical abuse by RI #115. On 07/01/2024 RI #115 hit RI #45.</p> <p>This deficient practice affected RI #45, but this did not rise to the Immediate Jeopardy Level.</p> <p>This deficiency was cited as a result of a Facility Reported Incident, complaint/report number AL00048276 .</p> <p>These deficient practices affected seven of 17 residents reviewed for abuse.</p> <p>Findings Include:</p> <p>Review of a facility policy titled Social Media Use, with an implemented date of 08/30/2023, and a revised dated of 05/07/2024 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Policy:</p> <p>It is the policy of this company to avoid inappropriate use of social media and to protect the residents . of this facility against misuse of social media content. Taking, keeping, or distributing unauthorized photographs or recordings of residents through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality. Staff members must recognize that they have an ethical and legal obligation to maintain resident privacy and confidentiality at all times.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. Employees are strictly prohibited from transmitting by way of any electronic media any resident-related image or information that may be reasonable anticipated to violate resident rights to confidentiality or privacy. This includes information that could degrade or embarrass the resident.</p> <p>2. Photographs or recordings of a resident and/or his or her private space without the resident's or designated representative's written consent, is prohibited. Examples include taking unauthorized photographs/videos of:</p> <p>a. a resident's room or furnishing (which may or may not include the resident).</p> <p>d. taking unauthorized photographs or recordings of residents in an state of dress or undress using any type of equipment .</p> <p>Review of a facility policy titled Personal Cell Phones, with a revised date of 05/07/2024 revealed:</p> <p>. Policy Explanation and Compliance Guidelines:</p> <p>1. This facility prohibits employees from using personal cell phones for any reason, on the nursing units or in working areas of the facility .</p> <p>3. Under no circumstances should employee take pictures, videos . of any resident .</p> <p>Review of a facility policy titled Resident Photographs, with a revised dated of 05/07/2024 revealed:</p> <p>Policy:</p> <p>Taking photographs and/or videos of residents or their personal belongings is a violation of residents' rights to privacy and confidentiality.</p> <p>Policy Explanation and Compliance Guidelines: .</p> <p>3. Any employee or past employee that takes photographs or videos of any resident that is not authorized will be considered abuse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>4. No current or past employee will post pictures, videos, comments, etc., on social media of any kind that pertains to anyone within this facility .</p> <p>Review of the facility's policy titled, Abuse, Neglect and Exploitation, with an implemented date of 08/30/2023, and a revised date of 05/07/2024, revealed:</p> <p>Policy</p> <p>It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of property.</p> <p>Definitions:</p> <p>Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology .</p> <p>Mental Abuse includes, but is not limited to, humiliation, harassment . Mental abuse also includes abuse that is facilitated or cued by nursing home staff taking or using photographs or recording in a manner that would demean or humiliate a resident(s) .</p> <p>Physical Abuse includes, but is not limited to hitting, slapping, punching, biting and kicking .</p> <p>Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents . regardless of their age, ability to comprehend, or disability .</p> <p>RI #101 was admitted to the facility on [DATE], and readmitted on [DATE]. RI #101 had diagnoses that included Aphasia Following other Cerebrovascular Disease and Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Dominant Side.</p> <p>A review of RI #101's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/04/2024, indicated RI #101's Brief Interview Mental Status (BIMS) was ten of 15, which indicated that RI #101 had moderately impaired cognition. RI #101 also had impairment on one side of the upper and lower extremities during the assessment period.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, submitted on 05/06/2024 at 9:20 PM documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #101) .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Name of alleged perpetrator(s): (CNA #18) .</p> <p>Narrative summary of incident:</p> <p>The Social Worker called the administrator to inform the administrator that she received a video from an outside source of our employee (CNA #18) mistreating one of our residents ,</p> <p>Action (s) taken by the facility in response to the incident.</p> <p>.The employee was contacted and asked not to come to work in the morning as scheduled. The employee will be called in for questioning and suspended pending investigation. The resident was assessed, and no injuries were noted. The resident was unable to answer question appropriately. The MD (Medical Director) and sponsor were notified. (local) Police Department was notified . Ombudsman was notified.</p> <p>The video of the incident was provided to ADPH. The video showed a resident, identified as RI #101, in the bed on his/her back clothed with pants and shirt. The resident was pointing with his/her right arm toward the right side of the bed where a CNA, identified as CNA #18, was standing. A smiley face emoji covered RI #101 for about ten seconds of the video as the CNA approached the bed. The staff recording the video, identified as CNA #19, and CNA #18 were speaking, but the audio was not clear enough to hear what was said. The emoji was removed, and RI #101 was positioned on his/her left side while his/her back was toward the camera and CNA #18. Next, CNA #18 grasped the top portion of RI #101's brief that was exposed above his/her pants and pulled upward forcible and with a jerking motion. Loud noises were heard on the video and CNA #18 stepped away from the resident. RI #101 repositioned himself/herself onto his/her back and immediately pointed at CNA #18. A staff's voice was heard saying you going to hell . (he/she) said stop playing with me . and laughing was heard. Another voice was heard saying, go on now while RI #101 was pointing at CNA #18. At this time, CNA #18 stepped back toward RI #101's bed and used the back of her right hand to swat at RI #101's right hand that was pointing at her. CNA #18 then swatted at RI #101's right hand with her left hand and appeared to swat his/her hand away. CNA #19 was laughing during the video.</p> <p>On 07/10/2024 at 2:39 PM, an interview was conducted with the DSS who said she became aware of the video and that it had been posted to social media in May of 2024 when an anonymous source sent a text to her phone. The DSS said when she first observed the video there was an emoji over RI #101's face. The DSS said CNA #18 pulled on the back of RI #101's pants extremely rough and after she pulled on RI #101's pants, RI #101 pointed at CNA #18. The DSS said RI #101's face was on the video. The DSS said she could see CNA #18 laughing and swinging her hands toward RI #101 and popping RI #101 on his/her hand. The DSS said CNA #19 was later identified as the person recording the video. The DSS said the incident would cause a reasonable person to feel embarrassed, like their privacy had been violated, and scared of the CNAs coming back and doing that to them again. The DSS said the incident was physical and emotional abuse.</p> <p>On 07/11/2024 at 5:47 PM, a follow-up interview was done with the DSS. The DSS said when she reviewed the video, RI #101 was not smiling from what she could see. When asked to describe RI #101's demeanor, the DSS said RI #101 looked frustrated to her.</p> <p>The facility's investigative file was reviewed and a handwritten EMPLOYEE STATEMENT dated 05/07/2024, and signed by CNA #18, documented the following:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On April 24, I was in (RI #101's) room giving (him/her) care and getting (him/her) dressed another employee recorded . it was a playing matter that just was took into the wrong way .</p> <p>On 07/10/2024 at 4:16 PM, a telephone interview was conducted with CNA #18. When asked what she could tell the surveyor about an incident involving a video being made of RI #101 when she provided care for him; and the video ended up on social media. CNA #18 said she was aware CNA #19 had her cell phone out but she was not aware CNA #19 was recording her providing care for RI #101 until the video came out and she was called into the ADM office. CNA #18 said the ADM discussed with her how she had grabbed and pulled RI #101's pants up forcibly. CNA #18 said the ADM said it looked like she had given RI #101 a wedgie. CNA #18 said her being rough with RI #101 could be considered physical abuse. CNA #18 when she saw the video it seemed like she was making fun of RI #101 and mocking him/her.</p> <p>The facility's investigative file contained a handwritten EMPLOYEE STATEMENT dated 05/07/2024 and signed by CNA #19 that documented:</p> <p>I (CNA #19) recorded the video to show fell ow employees . the video was sent from my phone .</p> <p>On 07/11/2024 at 8:28 AM, a telephone interview was conducted with CNA #19. CNA #19 said RI #101 could not physically speak. CNA #19 said a CNA requested her assistance and when she entered RI #101's brief was already fastened. CNA #19 said when she began recording, the other CNA was in the process of pulling RI #101's pants up. CNA #19 said she knew she was not to record anything about the resident, but she recorded the incident to show other staff. CNA #19 denied posting the video on social media.</p> <p>On 07/15/2024 at 8:55 AM a follow-up interview was conducted with CNA #19 via phone. CNA #19 said she did not know the video was posted on social media until the other CNA (CNA #19) called her later the evening the video was recorded and asked her to remove it from social media. CNA #19 denied posting the video on social media but said no one else had access to her phone. CNA #19 said she must have accidentally posted the video on social media.</p> <p>On 07/10/2024 at 5:16 PM, an interview was conducted with the ADM. who said when she viewed the video. The ADM said she the video showed CNA #18 pull up RI #101's pants forcibly. The ADM said RI #101 was on his/her side, and when RI #101 turned on his/her back RI #101 started pointing at CNA #18 and CNA #18 walked away and was laughing. The ADM said when CNA #18 returned, CNA #18 and RI #101's hand made contact, then CNA #18 laughed and walked away again. The ADM said identified CNA #18 in the video and notified her to not report to work as scheduled. The ADM said when CNA #18 was initially interviewed she was asked when she last worked with RI #101. CNA #18 out of the blue said April 24th and said she knew why she was being interviewed. CNA #18 revealed to her that CNA #19 was doing the recording. The ADM said the incident was physical abuse and could have easily affected RI #101 mentally when the resident's pants were pulled up forcibly, staff laughed about the situation, and the video was posted on social media for everyone to see.</p> <p>On 07/12/2024 at 7:30 AM during a follow-up interview with the ADM, she said when she reviewed the video, RI #101's pants were pulled up with force. The ADM said when RI #101 tuned over he/she pointed his/her finger at CNA #18. The ADM said she did not think RI #101 was smiling. When asked to describe RI #101's demeanor, the ADM said when RI #101 turned over RI #101 made a noise, pointed his/her finger and it seemed like RI #101 may have been a little upset for what CNA #18 had done to him/her.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Arabella Health and Wellness of Selma		STREET ADDRESS, CITY, STATE, ZIP CODE  11 Bell Road Selma, AL 36701	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 07/10/2024 at 8:47 AM, a telephone interview was conducted with RI #101's Responsive Party (RP). The RP said the facility made him aware a video of RI #101 had been posted to social media. When asked how he thought RI #101 would feel to know someone had videoed him/her and posted the video to social media, the RP said RI #101 would have been mad and would not have liked that at all.</p> <p>Review of the reported results from an onsite visit made by IBH (Integrated Behavioral Health) after the incident on 05/09/2024, revealed the following:</p> <p>. History of Present Illness . patient was reportedly abuse by a CNA at the facility and that the incident was recorded by a separate CNA. The patient is non-verbal . (He/She) is calm and pleasant. Interview is limited due to patient being non-verbal but (he/she) is able to participate by shaking (his/her) head yes or no, giving a thumbs up .</p> <p>The facility's incident summary dated 05/13/2024, documented: Physical Abuse .CONCLUSION</p> <p>(RI #101), resident, was provided care by (CNA #18) on April 24, 2024. While in the room providing care for (RI #101) (CNA #19) videoed (CNA #18) as she finished the care of (RI #101). In the video it was noted that (CNA #18) used aggressive force to pull up the pants of (RI #101). After forcefully pulling up the resident's pants, the employee is shown laughing and the resident is shown pointing at her . we can substantiate physical abuse .</p> <p>A review of the facility's IMMEDIATE QUALITY ASSURANCE REVIEW documentation regarding the incident revealed corrective action was initiated from 05/07/2024 through 05/14/2024.</p> <p>Upon review and verification of the information provided in the facility's corrective action plan, in-service/education records, the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 05/07/2024 to 05/14/2024, with on-going monitoring implemented; thus, immediate jeopardy past noncompliance was cited.</p> <p>2) RI #43 admitted to the facility 05/07/2015, with a diagnosis of Anxiety Disorder and Aphasia following Cerebral Infarction.</p> <p>A Quarterly MDS assessment with an ARD date of 01/26/2024, identified RI #43 to score a 12 of 15 on the BIMS indicating RI #43 had moderately impaired cognition.</p> <p>RI #86 was admitted to the facility on [DATE] and readmitted [DATE], with a diagnosis of Cocaine Abuse, Insomnia and Dysphagia, Oropharyngeal Phase.</p> <p>An Annual MDS assessment with an ARD date of 05/21/2024, identified RI #86 to score a 12 of 15 on the BIMS indicating RI #86 had moderately impaired cognition.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 03/06/2024 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail . Name(s) of resident(s) involved: (RI #43) .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Name of alleged perpetrator(s): (RI #86) .</p> <p>Narrative summary of incident: (RI #43) was rolling in (his/her) wheelchair down the hallway. (RI #86) was sitting in the hallway. (He/she) said (RI #43) ran over (his/her) foot and (he/she) hit (him/her) .</p> <p>The facility's incident summary dated 03/11/2024 documented:</p> <p>. Resident to Resident Physical Abuse .</p> <p>CONCLUSION</p> <p>(RI #86) was sitting on the hallway at the nurse's station. (RI #43) was ambulating down the hallway in (his/her) wheelchair and accidentally rolled over (RI #86's) foot. The two residents exchanged words and (RI #86), who has a history of trying to hit a resident (if) they try to run over (his/her) feet while (he/she) is sitting in the hallway, hit (RI #43) . we are substantiating resident to resident physical abuse with (RI #86) .</p> <p>On 07/11/2024 at 6:05 PM an interview was conducted with Licensed Practical Nurse (LPN) #11. She was asked to explain what she saw with RI #86 and RI #43, she said both were in wheelchairs in front of the nurses' station when she heard them cursing each other. LPN #11 said she saw RI #86 hit RI #43 on the arm and she and the CNA separated the two. LPN #11 said there was no sign of injury to either resident when assessed. LPN #11 said the incident was resident to resident physical abuse.</p> <p>3) RI #59 was readmitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Anxiety Disorder and End Stage Renal Disease.</p> <p>A Quarterly MDS assessment with an ARD of 04/11/2024 identified RI #59's had a BIMS score of 15 of 15 which indicated RI #59 was cognitively intact.</p> <p>RI #108 was admitted to the facility 03/02/2023, with diagnoses to include Adjustment Disorder with Mixed Anxiety and Depressed Mood.</p> <p>A review of RI #108's Annual MDS assessment with an ARD of 03/04/2024 indicated RI #108 had a BIMS score of 15 of 15 which indicated RI #108 was cognitively intact.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 04/27/2024 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #59) .</p> <p>Name of alleged perpetrator(s): (RI #108)</p> <p>What was reported . (RI #59) reported that (RI #108) hit (him/her) in (his/her) face .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Action(s) taken by the facility in response to the incident.</p> <p>The residents were separated . RI #108 is on one-to-one monitoring . No new injuries .</p> <p>The facility's incident summary dated 05/01/2024, documented that the facility's investigation determined:</p> <p>It was found that RI #108 engaged in a conversation with an employee in the dining room and proceeded to use profanity towards the employee. RI #59 intervened and asked RI #108 to leave the employee alone. The employee then witnessed RI #108 raising his/her hand at RI #59. As a result, RI #108 was escorted out of the dining room by the employee. Upon the employee's return, RI #59 informed her that RI #108 had hit him/her. Two other residents in the dining room confirmed witnessing RI #108 hit RI #59. Following a thorough review of acknowledgments and interviews, the facility confirmed resident-to-resident physical abuse.</p> <p>An interview was conducted with RI #59 on 07/12/2024 at 5:47 PM regarding the incident with RI #108. During the interview, RI #59 mentioned being in the dining room when RI #108 was verbally abusing an employee. RI #59 intervened and confronted RI #108 about the behavior, which resulted in RI #108 hitting RI #59, leaving a red mark on his/her face. RI #59 stated that there had been no additional incidents following the altercation.</p> <p>An interview was conducted with RI #108 on 07/13/2024 at 9:53 PM regarding the incident with RI #59. RI #108 said he/she was in the dining room and was talking to an employee. RI #108 said RI #59 got into the middle of the conversation and he/she told him/her to mind their own business. RI #108 said he/she raised his/her hand back but did not hit RI #59.</p> <p>An interview was conducted with Certified Nursing Assistant (CNA) #14 on 07/13/2024 at 10:44 AM regarding the incident involving RI #59 and RI #108. CNA #14 reported that while she was in the dining room, RI #108 became upset and started yelling and using profanity toward her. CNA #14 ignored RI #108, but RI #59 said something to RI #108 about the way he/she was talking. CNA #14 said she witnessed RI #108 approaching RI #59's table draw his hand back, but did not see RI #108 physically strike RI #59. CNA #14 intervened and separated the two residents and escorted RI #108 out of the dining room. Upon her return, RI #59 informed CNA #14 that RI #108 had hit him/her in the face. CNA #14 said RI #59's allegation was supported by two other residents who were sitting nearby. CNA #14 said this was considered physical abuse.</p> <p>An interview was conducted with the ADM on 07/13/2024 at 10:36 AM regarding the incident involving RI #59 and RI #108. The ADM stated that upon reviewing the investigation, she concluded that RI #108 physically abused RI #59.</p> <p>4) RI #48 was admitted to the facility on [DATE], with diagnoses to include Vascular Dementia and Major Depressive Disorder.</p> <p>A Quarterly MDS assessment with an ARD date of 04/16/2024, identified RI #48's BIMS was 12 of 15 which indicated that RI #48 had moderately impaired cognition.</p> <p>RI #95 was admitted to the facility on [DATE], with diagnoses to include Schizophrenia and Generalized Anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>An Annual MDS assessment with an ARD date of 04/30/2024, identified RI #95's BIMS was nine of 15 which indicated that RI #95 had moderately impaired cognition.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 05/06/2024 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail . Name (s) of resident (s) involved: (RI #95) .</p> <p>Name of alleged perpetrator(s): (RI #48) .</p> <p>Narrative summary of incident: . The residents were out on smoke break when (RI #48) asked for a cigarette. (RI #95) stuck (his/her) foot out and (RI #48) . slapped (RI #95) . The residents were separated . (RI #48) was sent to the (emergency room ) . (RI #95) was placed on one-to-one monitoring .</p> <p>The facility's incident summary dated 05/12/2024, documented: . Physical Abuse (Resident to Resident) .</p> <p>CONCLUSION</p> <p>The residents were taken outside to smoke . While outside (RI #95) and (RI #48) were arguing about cigarettes . (RI #95) stuck (his/her) feet out, (RI #95) and (RI #48) exchanged words and (RI #48) slapped (RI #95) .(RI #48) fell to the ground . we can substantiate physical abuse with (RI #48) and (RI #95) .</p> <p>The facility's investigative file was reviewed and revealed an interview done by the ADM with RI #118, 05/07/2024, which documented the following: . Physical Abuse . (RI #118), can you tell me what happened on the back porch yesterday, May 6, 2024? Answer: the residents were going back and forth with each other . (RI #48) walked over and slapped (RI #95) .</p> <p>On 07/12/2024 at 2:22 PM, during an interview with the ADM, she stated she substantiated that abuse had occurred. The ADM said following the incident, the facility began to take residents out to smoke in two separate groups and times to limit the number of residents smoking at one time.</p> <p>5) RI #123 was admitted to the facility on [DATE], with diagnoses to include Adjustment Disorder with Anxiety and Depression.</p> <p>A Quarterly MDS assessment with an ARD date of 04/15/2024, identified RI #123 BIMS was 15 of 15 which indicated that RI #123 was cognitively intact.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 06/12/2024 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Name(s) of resident(s) involved: (RI #43) .</p> <p>Name of alleged perpetrator(s): (RI #123) .</p> <p>Narrative summary of incident:</p> <p>There were 4 residents sitting at the table playing dominos. (RI #123) was asked to play, and (he/she) got mad and pushed the dominos down and spit on (RI #43). (RI #43) got up and hit (RI #123). Staff separated the residents .</p> <p>The facility's incident summary dated 06/19/2024, documented:</p> <p>. Physical Abuse .</p> <p>CONCLUSION</p> <p>The residents were in the dining room in an activity of [NAME]. It's usually the same group of people that play every day. (RI #123) is usually not in the dining room playing every day. (RI #123) was playing (his/her) dominos but was taking longer than the rest of the players. (RI #43) was trying to rush (RI #123) to play (his/her) dominos and they began to have a verbal altercation that led to a physical altercation . we can substantiate physical abuse .</p> <p>On 07/12/2024 at 12:04 PM, during an interview with the ADM, she recalled RI #43 and RI #123 were with a group playing dominos. RI #43 told RI #123 to hurry up and play and RI #123 said shut up and spit on RI #43. RI #43 got up to hit RI #123 but the CNAs got to them and separated them. RI #123 was placed on one-to-one supervision until he/she could be sent out when a bed became available. She said the form of abuse was resident to resident physical abuse. The ADM said following the incident interventions implemented included (but not limited to) education with the residents to not rush others while playing in the groups, and educated the staff when they first hear residents raise their voice to redirect or stop the games if necessary.</p> <p>6) RI #45 was admitted to the facility on [DATE], readmitted on [DATE] and discharged on [DATE].</p> <p>A Quarterly MDS assessment with an ARD date of 04/15/2024, identified RI #45's BIMS was 15 of 15 which indicated that RI #118 was cognitively intact.</p> <p>The Alabama Department of Public Health Online Incident Reporting System form, dated 06/24/2024 documented:</p> <p>. Incident Type . Abuse - Physical .</p> <p>Incident Detail .</p> <p>Name(s) of resident(s) involved: (RI #123) .</p> <p>Name of alleged perpetrator(s): (RI #45) .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Narrative summary of incident: The residents were in the dining room playing a game and (RI #123) spit on (RI #45). (RI #45) hit (RI #123) in the face .</p> <p>The facility's incident summary dated 06/27/2024 documented:</p> <p>. The residents were in the dining room playing dominos and (RI #123) and (RI #45) began to tap each other on the hand. (RI #123) said (RI #45) tapped him/her on the hand harder than he/she tapped him/her and (RI #123) spit in (RI #45's) face. (RI #45) hit him/her in the face. (RI #123) went down the hallway and told the nurse what happened . we can substantiate resident to resident physical abuse .</p> <p>On 07/11/2024 at 6:15 PM, RI #104, another resident who witnessed the incident between RI #45 and RI #123 was interviewed. RI #104 said he/she was sitting at the table while they were playing dominos back on June 24. RI #104 said RI #123 spit in RI #45's face, then RI #45 hit RI #123 around the nose area. RI #104 said RI #123 raised his/her arm to block the hit. RI #104 said he/she did not know if RI #45 hit RI #123's arm or actually hit RI #123 on the nose, but RI #45 hit RI #123. RI #104 said RI #123 got up and went to the nurses' station.</p> <p>On 07/12/2024 at 4:44 PM, a telephone interview was conducted with LPN #21. LPN #21 said RI #123 reported to her that RI #45 had hit him/her in the face. LPN #21 said she took RI #123 to his/her room and assessed RI #123. LPN #21 said she left RI #123 in his/her room with a CNA and went to find the other resident involved, RI #45. LPN #21 said RI #45 said he/she hit RI #123 because RI #123 spit in his/her face. When asked what type of abuse would this incident be considered, LPN #21 said physical.</p> <p>On 07/09/2024 at 5:19 PM, RI #123 was observed sitting on the side of the bed in his/her room. There was a sitter in the room who said someone had to be with RI #123 at all times. The surveyor asked RI #123 had he/she ever been in any type altercation with another residents. RI #123 said someone hit him/her in the face when they were playing dominos. RI #123 said it made him/her feel mad to be hit in the face. When asked why the other resident hit him/her in the face, RI #123 said he/she did not know.</p> <p>On 07/12/2024 at 2:22 PM, an interview was conducted with the DON. The DON said RI #45 hitting RI #123 in the nose was physical abuse. When asked what the facility had put in place to ensure an incident like this one would not occur again, the DON said RI #123 was place on one-on-one monitoring and dominos was made a supervised activity.</p> <p>7) RI # 115 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included Schizophrenia and Anxiety Disorder.</p> <p>RI #115's Quarterly MDS with AR [TRUNCATED]</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21055</p> <p>Based on observations, record review, interviews and review of a facility policy titled, Restraint Free Environment, the facility failed to ensure Resident Identifier (RI) #73's wheelchair (WC) seat belt was released during meal times on three of seven days of the survey 07/09/2024, 07/12/2024, and 07/15/2024.</p> <p>This deficient practice affected RI #73, one of one resident reviewed for the use of restraints.</p> <p>Findings include:</p> <p>RI #73 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include Unspecified Convulsions and Cerebral Palsy.</p> <p>Review of a facility policy titled, Restraint Free Environment, with a Copyright date of 2023, revealed the following:</p> <p>. Definitions:</p> <p>Physical Restraints refers to any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body .</p> <p>Compliance Guidelines: .</p> <p>5. Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints, and determine: .</p> <p>b. the time and frequency that the restraint will be released .</p> <p>RI #73's care plan titled, (Name of RI #73) uses a physical restraints (lap belt) ., with an initiated date of 07/06/2022, revealed the following intervention</p> <p>* Apply seat belt restraint while up in wheelchair and release during meal times .</p> <p>On 07/09/2024 at 12:59 PM, RI #73 was observed sitting in a WC with a seat belt intact around his/her waist.</p> <p>On 07/09/2024 at 1:12 PM, RI #73's lunch meal was served and RI #73 began to feed him/herself. RI #73's seat belt remained intact at this time.</p> <p>On 07/09/2024 at 1:24 PM, RI #73 continued to feed him/herself with the seat belt remaining intact around his/her waist.</p> <p>(continued on next page)</p>

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/09/2024 at 1:30 PM, RI #73 competed the lunch meal. The seat belt remained intact throughout the lunch meal.</p> <p>On 07/12/2024 at 8:19 AM, RI #73 was observed up in the WC feeding him/herself the breakfast meal. The surveyor again observed RI #73's seat belt intact around RI #73's waist.</p> <p>On 07/12/2024 at 12:45 PM, RI #73 was observed in his/her WC. RI #73's lunch tray was brought in and set up for resident to eat. RI #73's seat belt was again observed intact around RI #73's waist.</p> <p>On 07/12/2024 at 2:43 PM, an interview was conducted with Certified Nursing Assistant (CNA) #24. CNA #24 said RI #73 used a seat belt which should be released every two hours. CNA #24 said she did not know the seat belt should be released at meal times.</p> <p>On 07/12/2024 at 5:57 PM, an interview was conducted with Registered Nurse (RN) #25, the Unit Manager for the unit RI #73 resided on. RN #25 said RI #73 used a seat belt when up in the WC. RN #25 said according to RI #73's plan of care, the seat belt should be released during meal times. RN #25 said RI #73's belt is to be released to allow RI #73 free time from the restraint.</p> <p>On 07/12/2024 at 6:24 PM, an interview was conducted with the Licensed Practical Nurse/Minimum Data Set Coordinator (LPN/MDSC). The LPN/MDSC said any type devices that prevents a resident from rising or being able to freely move would be a restraint. The LPN/MDSC said a seat belt could keep a resident from being able to move freely. The LPN/MDSC said an intervention on RI #73's care plan was to apply the seat belt while up in the WC and release during meal times. When asked why it would be important to release the seat belt during meals times, the LPN/MDSC said one of the main reasons the seat belt was to be released was for free time for the resident.</p> <p>On 07/15/2024 at 6:00 PM, RI #73 was again observed feeding him/herself. RI #73's seat belt remained intact around RI #73's waist at this time.</p>		

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NAME OF PROVIDER OR SUPPLIER  Arabella Health and Wellness of Selma		STREET ADDRESS, CITY, STATE, ZIP CODE  11 Bell Road Selma, AL 36701	
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48195</p> <p>Based on observations, review of the medical record, and staff interview, and review the facility policy titled Restorative nursing Programs, the facility failed to ensure a splinting device for Resident Identifier (RI) #64's hand was in place on 07/09/2024 and 07/11/2024 to prevent decreased Range of Motion (ROM).</p> <p>Findings Include:</p> <p>Review of an undated facility policy titled Restorative Nursing Programs documented:</p> <p>Policy: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level.</p> <p>Definition: . This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning.</p> <p>RI #64 was admitted to the facility on [DATE] with a diagnosis of Multiple Sclerosis.</p> <p>RI #64's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/24/2024 noted RI #64's Brief Interview for Mental Status (BIMS) score to be 15 of 15 which indicated intact cognition.</p> <p>Review of RI #64's July Physician Orders documented:</p> <p>. RESTORATIVE NURSING: SPLINTS: LEFT HAND SPLINT/PALM GUARD RESIDENT CAN WEAR SPLINT 6-8 HOURS . 03/9/2022 . BRACE FOR LEFT HAND TO KEEP FINGERS EXTENDED .</p> <p>Review of RI #64's Care Plan documented a follows: RI #64 . has limited physical mobility r/t Neurological deficits .</p> <p>Intervention:</p> <p>SPLINT: LEFT HAND SPLINT/ PALM GUARD</p> <p>TIME/DURATION: RESIDENT CAN WEAR SPLINT 6-8 HOURS DAILY .</p> <p>On 07/09/2024 at 1:25 PM RI #64 was observed with left hand contracted and no splinting device was observed on the left hand of the resident.</p> <p>On 07/09/2024 at 4:25 PM RI #64 was observed with no splint to the left hand. RI #64 said he/she was supposed to be wearing the splint daily but staff did not put it on. RI #64 said the splint was in the basket on the bedside table.</p> <p>On 07/11/2024 at 10:39 AM and on 07/11/2024 at 12:24 PM RI #64's splint was observed on the bedside table.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>07/11/2024 at 5:54 PM RI #64's splint was observed on the bedside table. RI #64 said the hand brace/splint had not been on all day.</p> <p>07/12/2024 at 11:13 AM during an interview with Certified Nursing Assistant CNA #16 she said RI #64 required assistance with bathing, dressing, and could only reach with the right hand. CNA #16 said RI #64 had weakness on one side related to a stroke, and was to have assistive devices of an arm brace to left hand. CNA #16 said it was to be applied by the restorative staff.</p> <p>On 07/12/2024 at 11:23 AM during an interview with the restorative aide CNA #14, said her job duties were to perform the residents functional maintenance program after a resident comes off therapy. She said that included exercises such as walking residents, range of motion, and applying splints. CNA #14 said RI #64 received range of motion and a splint to his/her left hand. CNA #14 said the purpose of the splint was to keep RI #64's hand from contracting further. She said it was an important device, RI # 64's plan was to have splint applied four to five hours a day five to six times a week. CNA #14 said on 07/09/2024, 07/11/2024 and 07/12/2024 she was out of the building on appointments and no one performed her job or interventions if she was out of the building.</p> <p>On 07/12/2024 at 4:01 PM during an interview with the Restorative Nurse she said she was to oversee the restorative aides. The Restorative Nurse said RI #64 was to have a brace/splint to the left hand due to contractures, and was to wear the splint daily six to eight hours to keep contractures from getting worse. She said restorative staff were responsible for ensuring the splints were applied. She said RI #64's splint should have been applied.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>20304</p> <p>Based on observation, interview, the facility's 2024 Spring/Summer (S/S) Menu Diet Spreadsheets, the facility's production sheets, the facility's scoop/disher/dipper chart, and the facility's policies for The Dining Experience: Objectives, Menu Planning and Requirements, Menu Diet Spreadsheets/Portion Serving Communication Tool, Use of Production Sheets, and Menu Substitutions or Changes and Approval; the facility failed to provide pureed food items in the portions specified on the menu for supper on Tuesday, 07/09/2024 and for lunch on Thursday, 07/11/2024. The facility further failed to include cheese in the pureed entree as specified on the menu for supper on Tuesday, 07/09/2024 and did not receive approval from the Registered Dietitian (RD) to do so. In addition, the facility failed to provide the portion specified on the menu for Coleslaw on the Regular texture diets at supper on Tuesday, 07/09/2024, for trays on the [NAME] Wing cart. the facility also failed to provide the portion of ground Bratwurst for the Mechanical Soft texture diets as specified on the menu for lunch on Thursday, 07/11/2024. This had the potential to affect 4 of 4 Pureed texture diets, 5 of 7 trays for the [NAME] Wing, and 19 of 19 Mechanical Soft texture diets.</p> <p>Findings include:</p> <p>The facility's policy for The Dining Experience: Objectives, dated 2020, included the following:</p> <p>. Procedure: .</p> <p>4. Meals will be planned to meet nutritional adequacy and according to the resident's plan of care .</p> <p>The facility's policy for Menu Planning and Requirements, dated 2020, included the following:</p> <p>. Guideline: Menus are planned to provide nourishing, palatable, attractive meals that meet the nutritional needs of residents served, . in accordance with the Dietary Reference Intakes/Recommended Dietary Allowances as issued by the Food and Nutrition Board of the National Research Council, of the National Academy of Sciences, unless otherwise contraindicated by medical conditions and needs.</p> <p>Procedure: .</p> <p>2. Menus are planned in advance .</p> <p>8. Regular and therapeutic menus are planned by a nutrition professional in accordance to the community's approved diet manual. The planned menus are reviewed and approved by a registered dietitian (RD).</p> <p>The facility's policy for Menu Diet Spreadsheets/Portion Serving Communication Tool, dated 2020, included the following:</p> <p>. Guideline: Diet spreadsheets or similar meal and portion serving communication tools are available to the serving staff for reference and serving guidance.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's policy for Use of Production Sheets, dated 2020, included the following:</p> <p>. Guideline: A production chart/sheet is used during food preparation that lists the amounts to be prepared for all general food items and all modified diets in quantities needed for residents .</p> <p>The facility's policy for Menu Substitutions or Changes and Approval, dated 2020, included the following:</p> <p>. Guideline: . The registered dietitian (RD) . reviews . menu . changes for nutritional equivalency and appropriateness.</p> <p>On 07/09/2024 at 4:58 PM, preparation for Supper was observed. The PM [NAME] explained that the production slip for Supper was posted on the wall in the Cook's Area; it was a small paper square with the following information: 98 Reg (Regular), 4 Puree, and 20 M/S (Mechanical Soft). The Kitchen Supervisor then said Production Meetings were at 10:00 AM and 2:00 PM daily. The Kitchen Supervisor also pointed out the 2024 S/S Menu (Week 2 Diet Spreadsheet) with portion sizes, which was posted on the bulletin board in the main kitchen area.</p> <p>On 07/09/2024 at 5:14 PM, temperatures were being taken of the Supper items on the steamtable by the PM Cook. The Coleslaw was in a full pan, which was placed atop a pan of ice at the end of the steamtable. A 3-ounce spoodle was observed as the serving utensil for the Pureed Hamburger Patty and Bun and this was verified by the PM Cook. The PM [NAME] said Cheese was not included in the pureed entree because there might be a Renal puree to be served. The 2024 S/S Menu Diet Spreadsheet for Week 2, Tuesday, Supper listed Pureed Cheeseburger on Bun with a #6 dip (dipper) portion utensil (5.3 fluid ounces) for the Pureed texture diet.</p> <p>On 07/09/2024 at 5:35 PM, the Supper trayline began with the loading of the [NAME] Wing Cart. The Dietary Manager said, although the Dining Room was listed to be served first, it could not be served until Residents and CNAs were present and ready. At 5:40 PM, the [NAME] Wing Cart left the kitchen. At 5:41 PM, a scoop/disher/dipper was observed being used to serve the Coleslaw in insulated soup bowls. At 5:46 PM, the surveyor asked size of the Coleslaw scoop/disher/dipper and then saw it was a #16 scoop/disher/dipper (2 ounces) from the number 16 imprinted on the metal. When the Kitchen Supervisor realized a #16 scoop/disher/dipper was being used for serving the Coleslaw, instead of a #8 dip (4 ounces) as per the menu (2024 S/S Menu Diet Spreadsheet for Week 2, day 10, Tuesday, Supper); she told the PM [NAME] to serve half a scoop (half of a #16 scoop/disher/dipper). The Kitchen Supervisor was asked if there was a #8 scoop/disher/dipper in the kitchen. The Kitchen Supervisor went to the Cook's Area and came back with a 4-ounce spoodle. The Kitchen Supervisor said no #8 scoop/disher/dipper was available.</p> <p>On 07/09/2024 at 6:06 PM, the surveyor looked for any posting of a disher/scoop/dipper conversion chart in the kitchen, but there was not one. When asked about a disher/scoop/dipper conversion chart to identify the ounces or cup size for each number size of disher/scoop/dipper; the Dietary Manager said he had seen one in another facility recently and thought that would be good for his kitchen, but they did not currently have one. The Dietary Manager was asked if the RD had been told of the decision to leave cheese out of the pureed hamburger patty and bun mixture and if she had given approval for that change to the menu. The Dietary Manager said no.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/10/2024 at 5:20 PM, the Dietary Manager displayed a small conversion chart for scoops/dishers/dippers, spoodles, cup sizes, and ounces he had printed out. The Dietary Manager said he would be using it to teach the staff about portions and that he was going to post it on the wall by the steamtable. The Basics at a Glance conversion chart included the following:</p> <p>#6 scoop/disher/dipper equals 2/3 cup or 5.3 fluid ounces</p> <p>#8 scoop/disher/dipper equals 1/2 cup or 4 fluid ounces</p> <p>#16 scoop/disher/dipper equals 1/4 cup or 2 fluid ounces</p> <p>The Dietary Manager also said he was ordering more #8, #12, #16 scoops/dishers/dippers.</p> <p>On 07/11/2024 at 11:03 AM, the staff was preparing for the Lunch meal. At 11:21 AM, covered food pans were being placed on steamtable. At 11:30 AM, the food temperatures on the steamtable were being checked. The following serving utensils were observed to be incorrect for the portions listed on the 2024 S/S Diet Spreadsheet for Week 2, Day 12, Thursday, Lunch:</p> <p>Ground Bratwurst had a 3-ounce spoodle for service, but the menu listed a #8 dipper (4 ounces) for the Mechanical Soft (Mech Soft) diet entree.</p> <p>Pureed Bratwurst had a 3-ounce spoodle for service, but the menu listed a #8 dip (4 ounces) for the Pureed diet entree.</p> <p>Pureed Seasoned Diced Potatoes had a 3-ounce spoodle for service, but the menu listed a #8 dip (4 ounces) for the Pureed diet starch/potato.</p> <p>Service of the Lunch trayline began at 11:47 AM.</p> <p>On 07/11/2024 at 12:32 PM, the Kitchen Supervisor was asked for copies of the production sheets used for Supper on Tuesday (Day 10) and for Lunch today (Day 12, Thursday). The Kitchen Supervisor explained that the number of servings on the production sheets were not correct. The Kitchen Supervisor said they were mainly using the sheets for the menu items that needed to be prepared and for the portion sizes to be served.</p> <p>1. The production sheet for Supper - Day10 - Tuesday included the following:</p> <ul style="list-style-type: none"> <li>. Pureed Cheeseburger on Bun (Pureed) . #6 dip .</li> <li>. Coleslaw . #8 dip .</li> </ul> <p>2. The production sheet for Supper - Day12 - Thursday included the following:</p> <ul style="list-style-type: none"> <li>. Ground Bratwurst w/Gvy [with Gravy] (Dental Soft (Mech Soft)) . #8 dipper .</li> <li>. Pureed Bratwurst (Pureed) . #8 dip .</li> <li>. Pureed Seasoned Diced Potatoes (Pureed) . #8 dip .</li> </ul> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/11/2024 at 12:46 PM, while the trayline was stopped to wait on additional sauteed peppers and onions, the AM [NAME] and the Diet Aide/Relief [NAME] were asked about Pureed diets. Each said there were only four Pureed diet plates for lunch today and none of the those were Renal diets.</p> <p>On 07/11/2024 at 1:02 PM, upon the completion of the trayline Lunch service; the Kitchen Supervisor, the AM Cook, and the Diet Aide/Relief [NAME] each confirmed that 3-ounce spoodles were used to serve the Pureed Bratwurst and the Pureed Seasoned Diced Potatoes. When asked if they had been instructed to use the 3-ounce spoodles for puree foods, the Kitchen Supervisor said yes.</p> <p>On 07/12/2024 at 10:33 AM, the Registered Dietitian (RD) was interviewed by phone. The RD was asked the problem with serving a smaller portion than listed on the menu. The RD said there was a potential of not meeting the residents' nutritional needs if the wrong scoop (scoop/disher/dipper) was consistently used. When asked why it was important to check with the RD before changing the menu; the RD said we are providing an adequately balanced diet throughout the day so we want to make an appropriate substitution if something is changed,</p>		