STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015406	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arabella Health & Wellness of Grand Bay	13750 Highway 90 West Grand Bay, AL 36541

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 interviews, resident record reviews, review of a facility policy titled Abuse, Neglect and Exploitation, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to protect the residents' right to be free from sexual, physical, and verbal abuse perpetrated by staff and residents. 1.) On 01/13/2025 at approximately 2:00 AM, Licensed Practical Nurse (LPN) #13 observed Resident Identifier (RI) #44's call light was on. The Certified Nursing Assistant (CNA) assigned to care for RI #44, CNA #23, was on her lunch break at that time and the CNA assigned to care for RI #20, CNA #12, was not permitted to enter RI #44's room. LPN #13 administered medications to another resident and then responded to the call light. Upon entering the room, LPN #13 witnessed RI #20 sitting on RI #44's bed next to RI #44 who had severely impaired cognition and did not have the capacity to consent to the situation. RI #20 was nude from the waist down and was looking at RI #44 and caressing RI #44's hip and thigh. RI #44's Responsible Party (RP) reported RI #20 had previously entered RI #44's room and was looking at RI #44's roommate who had disrobed. The RP also reported that more recently, they had observed RI #20 masturbating in his/her room with the door open and looking into RI #44's room. The Medical Director (MD) also reported that RI #20 would look in at a resident (identified as RI #33) while the resident was undressing. The MD said, because RI #20 would watch the other resident undress, the other resident had been moved to another room. The medical record indicated that the resident, identified as RI #33, was moved to the [NAME] Wing on 10/10/2024. Following the incident on 01/13/2025, RI #20 was also moved to the [NAME] Wing. The facility failed to communicate RI #20's behaviors to staff and ensure interventions were developed and implemented to ensure RI #20 was supervised in a manner to protect other residents. Specifically, the CNAs who were assigned to RI #20's and RI #44's care at the time of the incident occurred reported they were unaware of that RI #20 had previous sexual behaviors. Further, the facility failed to report the incident to the State Agency until 01/16/2025 when LPN #13 resigned via email and cited one of her reasons for resignation was that the incident of sexual assault had not been reported. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/11/2025 at 5:26 PM, the Administrator (ADM), the Director of Nursing (DON), the [NAME] President of Risk Management, the [NAME] President of Clinical Operations, and the Senior Regional Director of Clinical Operations were provided a copy of the IJ template and notified of the findings of immediate jeopardy and substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F600- Free from Abuse and Neglect. The IJ began on 01/13/2025 and continued until 04/14/2025 when the survey team verified onsite that corrective actions had been implemented. On 04/15/2025 the immediate jeopardy was removed, F600 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as the result of the investigation of complaint /report number AL00049904. The facility further failed to ensure RI #20 and RI #219 were protected from physical and verbal abuse that did not rise to the jeopardy level. 2.) On 06/13/2024 the facility failed to protect RI #20 from physical abuse when RI #31, a resident who exhibited unmanaged aggressive verbal and physical behaviors, hit RI #20 in the back of the head three or four times. Staff who witnessed the abuse said anyone would be upset after being hit in the head. 3.) On 05/20/2024, the facility failed to protect RI #219 from physical abuse when RI #42, a resident with a history of behaviors, hit RI #219 and pushed RI #219's head into the pillow while RI #219 was in bed. A witness to the incident said, RI #219 was scared by the abuse. Three of 27 residents sampled for abuse were found to have been abused as determined by the investigations of complaint/report numbers AL00049904, AL00048142, and AL00047903. Findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, with an implemented date of 11/16/2024, and a revised date of 11/18/2024, revealed: Policy: 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 resident property. Definitions: 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 . It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment . Sexual Abuse is non-consensual sexual contact of any type with a resident . Verbal Abuse means the use of oral, written or gestured communication sounds that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance regardless of their age, ability to comprehend, or disability . Policy Explanation and Compliance Guidelines: . 3. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The components of the facility abuse prohibition plan are discussed herein: . III. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect . that achieves: . B. Identifying, correcting and intervening in situations in which abuse . is more likely to occur with the deployment of trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents and assure staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; . D. The identification, ongoing assessment, and care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict . 1.) Cross-Reference F609, F610, F740, F835, and F867. RI #44 was admitted to the facility on [DATE] and had diagnoses that included Intellectual Disabilities, Microdeletions, and Lack of Expected Normal Physiological Development in Childhood. RI #44's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/24/2024 documented the resident had long-term and short-term memory loss with no memory or recall ability. RI #44's Brief Interview for Mental Status (BIMS) was not assessed because the resident rarely/never understood. RI #20 was admitted to the facility on [DATE] and had a diagnosis of Intercranial Injury with Loss of Consciousness. RI #20's quarterly MDS with an ARD of 12/06/2024 documented a BIMS score of four out of 15, which indicted severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of RI #20's Care Plan Report revealed: . RI #20 has behavior indicators. (He/She) is sometimes aggressive toward peers and requires redirection. At risk for altercation, complications associated with behavior issues . start date 3/1/2024 . Status Active . When acute behaviors are noted, intervene promptly to manage/redirect . A review of RI #20's Comprehensive Care Plan submitted by the facility immediately following the survey revealed: . Behaviors will be identified and minimized or eliminated without causing harm to resident or staff during acute episode . with appropriate intervention . meds, redirection, diversional activities etc . The Care Plan included the other interventions and start dates including . (RI #20) has had episodes of being sexually inappropriate in the common areas of the facility. Staff is to redirect resident. Start Date 06/05/2024 . Further review of the Comprehensive Care Plan revealed that RI #20 had an intervention related to him/her wandering to roommates side of room. The Care Plan did not include interventions to address RI #20 wandering into other residents' rooms. The facility submitted a Facility Reported Incident (FRI) via the State Agency on 01/16/2025 at 1:30 PM. The FRI was the initial report and indicated LPN #13 submitted a resignation with accusations of sexual assault from a prior incident between RI #44 and RI #20. The report indicated the alleged incident occurred on 01/13/2025 at 2:00 AM. The facility investigative file contained a handwritten Nurse's Note dated 01/13/2025 and signed by LPN #13. The Nurse's Note documented . (CNA #42) came to nurses station to report resident . needed pain medicine. (RI #44's room number) call light came on. As nurse was getting up to pull pain medication no CNA had gotten up to answer the call light. Nurse passed the medication and then went to answer the call light. As nurse was approaching the room she was startled to see (RI #20) without a brief sitting in the bed with (RI #44) looking at (RI #44) and caressing (RI #44's) hip and thigh. As (RI #20) and the nurse made eye contact (RI #20) was startled and immediately stopped touching (RI #44). Nurse ran to the day room looking for (RI #20's) CNA and some assistance. (RI #20) was immediately removed from (RI #44)'s room and returned to (his/her) room. (RI #20) who's room is across the hall from (RI #44) was placed in room (different room number) . (ADM) was immediately called. CNA's were interviewed nurse determined no CNAs assigned were at fault but all were asked to provide statements. Per orders of Administration (RI #20) has been removed from East Wing . to [NAME] Wing . The investigative file also contained a printed email dated 01/16/2025 at 11:14 AM from LPN #13 to the ADM. The email included: . Due to the events that transpired between (RI #44 and RI #20) on 01/13/2025 . I can not and will not associate myself with abuse and this is SEXUAL ASSAULT . In this particular matter my patient has no voice, due to (his/her) limitations of (him/her) being non-verbal . I have provided a detailed account of the events . that can be verified by video footage. Surveyors attempted and were unable to reach LPN #13 for interview during the survey. Surveyors attempted and were unable to view video footage during the survey. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/08/2025 at 2:17 PM an interview was conducted with CNA #25 who reported she was working on the [NAME] Wing on 01/13/2025 when the incident occurred. CNA #25 said LPN #13 went to the [NAME] Wing and asked about moving RI #20 to the [NAME] Wing. CNA #25 said LPN #13 told her that RI #20 was found in RI #44's room sitting on RI #44's bed on top of the covers with his/her hand on RI #44's hip and a massaging motion was observed. An interview with CNA #23 was conducted on 04/23/2025 at 2:57 PM. CNA #23 recalled her shift on 01/13/2024, when she was assigned to care for RI #44. She remembered upon her return from her lunch break, LPN #13 informed her that RI #20 had been discovered in RI #44's room. CNA #23 recalled observing RI #20 sitting on the side of the bed earlier while she was assisting RI #44 to the shower, and she stated that this was unusual because RI #20 was typically sleeping at that hour. An interview with CNA #12 was conducted on 04/09/2025 at 6:10 PM. CNA #12 reported that she was assigned to care for RI #20 on 01/13/2025. CNA #12 said LPN #13 informed her of the after the incident had taken place that RI #20 was discovered in RI #44's room, seated on RI #44's bed, and had been relocated to another room. CNA #12 stated, she did not see RI #20 after receiving this information from LPN #13. The facility's investigative file contained a Nurse's Note dated 01/13/2025 that documented I (CNA #12) can not go into (RI #44's roommates) room . So I did not answer (his/her) light! . I did not know where (RI #20) was at or that (he/she) had entered (RI #20)'s room. An interview was conducted with LPN #22 on 04/03/2025 at 2:52 PM. LPN #22 was asked to recall the incident involving RI #20 and RI #44. LPN #22 stated, she was working with LPN #13 on 01/13/2025 and assisted LPN #13 with performing a body audit of RI #44. The facility investigative file contained a document titled Investigation Conclusion dated 01/24/2025 signed by the administrator which documented: . The incident/allegation of sexual abuse is unsubstantiated. The report was generated after the nurse resigned based on the verbiage of her resignation letter. RI #20 was found sitting on the edge of RI #44's bed naked from waist down. When the nurse entered the room, she witnessed RI #20 touching RI #44 on the thigh and hip. RI #20 has wandering tendencies but has never had any issues nor sexual tendencies with any other male or female residents. RI #44's brief was secure and intact and no sign of displacement. RI #44 is non-verbal and RI #20 has severe short term memory. RI #20 was questioned and denied the allegations . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted with the Administrator/Abuse Coordinator (ADM) on 04/03/2025 at 3:30 PM. The ADM said RI #20 had wandering behaviors and had entered into other residents' rooms and staff redirected RI #20. The ADM reported that at approximately 2:00 AM on 01/13/2025, he received a phone call from LPN #13, who informed him that she had seen RI #20 sitting beside RI #44's bed, unclothed from the waist down, and that RI #20 was touching RI #44's waist and thigh. The ADM said he inquired whether the two residents had been separated and if there was any indication of sexual contact. According to the ADM, LPN #13 indicated that there did not appear to be any sexual contact between the two residents. Based on the information provided by LPN #13 at the time, the ADM concluded he did not believe sexual abuse had occurred. The ADM said the incident was not reported within two hours to the State Agency because, he did not feel like it was abuse initially. The ADM said if LPN #13 said RI #20 was masturbating or he/she had an erection he would have reported the incident immediately. The ADM said he did not know how RI #20 was able to enter RI #44's room without staff knowing. The ADM said there were three CNAs and two nurses working at the time of the incident. The ADM stated LPN #13 gave two accounts regarding what she did when she found RI #20 in RI #44's room, in one note she said she immediately separated the residents and in another she said she went and got help. The ADM stated the facility tried to clarify LPN #13's statements, but she refused. A review of the facility's investigative file revealed there was no documented interviews or statements that indicated RI #20 was or was not masturbating or whether or not RI #20 had an erection. A follow-up interview was conducted with the Administrator on 04/09/2025 at 12:21 PM. The ADM was asked if he was able to determine how long RI #20 was in RI #44's room he said he did not know. He said the investigation found that a staff member witnessed RI #20 in RI #44's room with no clothes on from the waist down and touching RI #44's leg. An interview with the DON was conducted on 04/03/2024 at 4:45 PM. During the interview, she was questioned about the incident that occurred on 01/13/2025 involving RI #20 and RI #44. The DON stated, she was informed of the situation by the ADM while enroute to work on the same day. She was briefed on the events, during which RI #20 was discovered in RI #44's room, unclothed from the waist down, and making contact with RI #44's leg. When asked whether this constituted sexual abuse, the DON indicated there was no evidence to suggest RI #44 had been sexually abused by RI #20, because RI #44's brief was intact. When questioned about her reasoning for not classifying the incident of a resident sitting on another resident's bed, unclothed from the waist down and touching their leg, as sexual abuse, she explained, RI #20 did not have an erection and was not engaging in masturbation at the time. When asked how a reasonable person might react if someone entered their room, sat on the edge of their bed, was unclothed from the waist down, and touched their leg, she acknowledged that they would likely feel upset. On 04/10/2025 at 6:13 PM a follow-up interview was conducted with the DON, who was asked what level of supervision RI #20 required. The DON said RI #20 required limited assistant with activities of daily living and staff spot checked him/her. The DON said after the one-on-one observations were discontinued on 01/14/2025 the facility staff monitored RI #20 every 15 minutes. The DON said RI #20 was seen by the facility's psychiatric services and they said RI #20 did not need to be on one-on-one observation so they initiated Q15 (every 15) minute checks from 01/15/2025 through 01/30/2025 for elopement and to know where RI #20 was in the building. The DON said staff were still doing close monitoring but it was not being documented. The DON was asked, how did staff know to perform close monitoring. The DON said she did not know but guessed by word of mouth. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/13/2025 at 3:52 PM the facility provided forms titled Resident Observation/Monitor Tool that documented ongoing monitoring every 15 minutes was being documented beginning on 01/15/2025. ********** On 04/15/2025, the facility submitted an acceptable removal plan, which documented: F 600 Removal Plan 04/15/2025 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: a. The facility failed to protect Resident #44's right to be free from sexual abuse. On 01/13/2025 at approximately 2:00 AM, LPN #13 observed Resident #20 seated on Resident #44's bed. Resident #20 was nude from the waist down and was caressing Resident #44's hip and thigh. Resident #44 has severely impaired cognition and lacked the capacity to consent to the situation. b. LPN #13 removed Resident #20 from Resident #44's room on 1/13/25 at approximately 2 am and initiated 1:1 supervision for Resident #20 to ensure safety and prevent further incidents. c. Resident #44 was assessed by LPN #13 and another LPN on 1/13/25 at approximately 2:30 am. d. Behavioral Health was contacted and assessed resident on 1/14/25 - Recommendation was to discontinue 1:1 sitter and initiate Q 15-minute checks while medications have time to become efficacious. Q 15 min checks were initiated by the DON in alignment with nationally recognized nursing practice standards, close monitoring is defined as visual checks every 15 minutes. This frequency is commonly accepted in clinical practice for residents identified as high-risk, including during behavioral concerns, elopement risk, or post-incident observation. The assigned staff were to complete the documentation flow sheet. Charge nurses verified staff were monitoring and observing resident every 15 minutes, and staff submitted the flow sheet to the DON for review when completed. Recommendations from Behavioral Health (BH) were reviewed by the Director of Nursing (DON) or designee. The DON/designee followed the recommendations of the psych provider. The resident continues on Q 15-minute checks and has had no behaviors since 1/13/2025. e. On 04/11/2024, the [NAME] President of Risk Management conducted an in-service for the Administrator and Director of Nursing covering all types of abuse and the facility's responsibility to ensure resident safety. f. On 4/12/25 [NAME] President of Risk Management provided in-service for the Administrator and Director of Nursing training on the facility's Elopement and Wandering Resident Policy, emphasizing strategies to prevent residents from entering others' rooms and reduce the risk of unsafe wandering and potential for abuse. 2. Identification of Other Residents Having the Potential to Be Affected (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. This incident had the potential to affect vulnerable residents that are unable to consent residing in the facility. RI # 20 continues on Q 15 min checks and has had no behaviors since 1/13/2025. All residents with BIMS of 10 or greater were interviewed by Care Manager/designee on 4/13/25 using the Abuse screening interview form, if BIMS less than 10 form allows for staff observation. With no abuse findings. b. On 04/12/2025, the Director of Nursing and the Regional Nurse Consultant conducted comprehensive wandering risk assessments on all residents to identify individuals who may be at risk of entering other residents' rooms and potentially posing a threat of abuse. c. All resident were assessed using Wandering behavior clinical form by the Care Manager/designee on 4/12/25 for wandering and going into other rooms. 8 residents had wandering tendencies and 6 had known history to go into others' rooms. Of the 6 residents who enters others' rooms their BIMS scores are low indicating at least intermittent confusion and they are redirectable. The 8 residents with wandering tendencies' care plans were reviewed by Regional Director of Clinical Reimbursement on 4/14/25 to ensure they were appropriate, and person centered and that they considered safety of all residents. No additional residents were identified as posing a threat of abuse. This was determined using the Staff Abuse awareness and Reporting Questionnaire completed by the Administrator/designee on 4/13/25. 3. Actions Taken / Systems to Be Put into Place to Reduce the Risk of Future Occurrences a. On 04/12/2025, the [NAME] President of Risk Management and the Regional Nurse Consultant provided one-on-one in-service training to the Administrator and Director of Nursing on the facility's Abuse Policy. This policy emphasizes that all residents have the right to be free from sexual abuse, outlines how to identify abuse, and mandates immediate protection of residents when abuse is suspected or observed including to immediately remove the perpetrator from any potential victim by separation of the resident from the aggressor. b. On 4/12/25, the [NAME] President of Risk Management and Regional Nurse Consultant provided one-on-one in-service training on the Elopement and Wandering Residents Policy with the DON and the Administrator. Residents identified at risk for unsafe wandering will be assessed quarterly, on admission and with significant changes. Individualized, person-centered care plans will be developed, implemented, monitored, and revised as necessary. c. On 4/11/2025 All CNAs were trained on the process to ensure that CNAs are stationed in the corridor of the patient care areas for visualization of their assigned rooms throughout the day and night shifts. Training included that break times will be assigned prior to the beginning of both shifts prior to beginning of both shifts by charge nurse to ensure supervision. DON/designee will monitor the schedule for staff who have not completed the training. DON/designee will provide training prior to the start of the shift. Staff not physically present were in-serviced via phone. No staff are permitted to work until this training is completed Facility-wide staff training began. 35 of 38 CNAs trained. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. The charge nurse on the hall is responsible for monitoring the CNAs to ensure they are following the process and to ensure break times are scheduled prior to beginning of both shifts. The charge nurses were trained on this process on 4/11/2025. DON/designee will monitor the schedule for staff who have not completed the training. DON/designee will provide training prior to the start of the shift. Staff not physically present were in-serviced via phone. No staff are permitted to work until this training is completed Facility-wide staff training began. 23 out of 25 Nurse trained. This process began on 1/14/25 to monitor resident movement during the shift, and reduce the risk of residents entering others' rooms, and reduce the risk of abuse. e. Break times will be assigned by the charge nurse prior to the beginning of both shifts to ensure supervision, beginning 4/12/25. f. Facility-wide staff training was began on 04/11/2025, by the Director of Nursing/ designee covering abuse policy. This policy emphasizes that all residents have the right to be free from sexual abuse, outlines how to identify abuse, and mandates immediate protection from non-consensual contact/touching, masturbation, indecent exposure toward residents when abuse is suspected or observed, by physically moving the resident and the aggressor away from each other and not leaving the perpetrator without 1:1 supervision until seen by medical provider. When abuse is suspected or observed report to Facility requests IJ removal plan to be effective on 04/15/2025. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/14/2025. 2.) Cross reference F740. On 06/13/2024 at 1:50 PM the State Agency (SA) received a Facility Report Incident (FRI) alleging RI #20 was physically abused by RI #31 who approached RI #20 from behind, swatted RI #20 several times, hitting RI #20 in the upper back and back of the head, without visual injury, and RI #20 told staff he/she did not feel threatened and was not scared. The FRI continued, RI #31 had demonstrated worsening agitation during the week and was being monitored, the facility assigned a CNA to be with RI #31 at all times until they received a physician order to indicate what to do, and RI #31 would be sent out to the hospital for evaluation. RI #20 was admitted to the facility on [DATE] and had diagnoses to include Epilepsy. RI #20's quarterly MDS assessment with an ARD of 06/07/2024 documented a BIMS score of three of 15 indicating severe cognitive impairment. RI #31 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Alzheimer's Disease. RI #31's quarterly MDS assessment with an ARD of 05/28/2024 documented a BIMS score of three of 15 which indicated severe cognitive impairment. (continued on next page)

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	015406	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arabella Health & Wellness of Grand Bay	13750 Highway 90 West Grand Bay, AL 36541

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #31's care plan for a history of behaviors with a start date of 01/30/2024 described behaviors of being combative with caregivers and at risk for altercations. The facility investigative file contained a handwritten statement, signed by CNA #16 who witnessed the abuse, which documented: June 13, 2024 It was 11:50am, (RI #20) was sitting in (his/her) wheelchair . (RI #31) walked up behind (RI #20) unprovoked and hit (him/her) 4 (four) times open palm in the back. I (CNA #16) blocked (RI #31) from hitting (him/her) again, and separated them. On 04/08/2025 at 9:19 AM an interview was conducted with CNA #16 who witnessed the incident on 06/13/2024 between RI #20 and RI #31. She said, RI #20 was in the hallway and RI #31 thought RI #20 was his/her child who had stolen RI #31's money. RI #31 hit RI #20 in the back of the head three or four times with an open palm. CNA #16 said, she intervened to separate the residents. CNA #16 said, what she witnessed was physical abuse. CNA #16 was asked how would a reasonable person feel about being hit in the back of the head. She said, anyone would be upset about being hit in the back of the head. On 04/08/2025 at 10:26 AM an interview was conducted with LPN #17 who was the nurse at the time of the incident on 06/13/2024. LPN #17 said, they were in the television room and RI #31 was agitated and thought RI #20 was his/her child, whom RI #31 thought (He/she) stole everything we had. LPN #17 said, she instructed RI #20 to go to his/her room and as RI #20 began to go down the hall, RI #31 got up and power walked quickly up behind RI #20 and hit RI #20 in the back of the head three times. LPN #17 said, the residents were separated, body audits revealed no injury, and she thought the physical abuse of being hit in the head surprised RI #20. LPN #17 said, a reasonable person would be upset about being hit in the back of the head. LPN #17 said, RI #31's behaviors and agitation could have increased that week due to Dementia, and some days RI #31's agitation was worse. The facility investigative file contained a typed statement signed by the ADM, dated 06/13/2024, which documented: (11:50 AM), (RI #31) approached (RI #20) and swatted at (him/her) 3-4 times in the back of the upper back and head. (CNA #16) observed (RI #31) approaching (RI #20) and stopped (him/her) as (he/she) began swinging at (RI #20). The two were separated and checked for injuries. (RI #31) had a person assigned to (him/her) for the rest of the evening to monitor . (RI #31) was sent out to the hospital for evaluation. On 04/09/2025 at 11:08 AM the ADM was asked about the incident between RI #31 and RI #20. The ADM said, when RI #31 hit RI #20 in the back of the head with an open palm it was physical abuse. When asked how a reasonable person would feel about being hit in the back of the head with the palm of the hand, he said a reasonable person would have been surprised. The ADM said, RI #31 had increased agitation that week probably due to Dementia. 3.) Cross reference F609. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 05/20/2024 at 6:52 AM the State Agency received a Facility Reported Incident (FRI) alleging physical abuse occurred between roommates, when RI #219 told RI #42 to quit cussing and RI #42 got out of bed and assaulted RI #219 resulting in one having a bruise and the other having a cut, the victim was moved to another room and both residents were evaluated and monitored for injury and well being; family members were notified, physician was notified, and ongoing monitoring was being performed on both residents. RI #219 was admitted to the facility on [DATE] and had diagnoses that included Hypertensive Heart and Chronic Kidney Disease. RI #219's quarterly MDS assessment with an ARD of 04/26/2024 documented a BIMS score of 15 of 15 indicating RI #219 was cognitively intact. RI #42 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Alzheimer's Disease. RI #42's quarterly MDS assessment with an ARD of 05/02/2024 documented a BIMS score of three of 15 indicating severely impaired cognition. RI #42 had a history of behavior included on a Behavioral Health (BH) assessment dated [DATE], that included: confusion, agitation, irritability, difficult to redirect, broken sleep, tends to be up all night, and fights with roommate. The facility investigative file contained a handwritten statement dated 05/19/2024 and signed by CNA #18 which documented: When I got to the room of (RI #219 and RI #42) around 11:45 pm. (RI #42) was standing beside (RI #219's) bed. The two . were hitting, yelling and cussing at one another. On 04/07/2025 at 2:38 PM CNA #18 was asked about the incident involving RI #42 and RI #219 that occurred on 05/20/2024. CNA #18 said she heard the residents arguing and yelling and went to the room. CNA #18 said, when she entered the room, RI #42 was over at RI #219's bed, they[TRUNCATED]

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, the facility's investigative file, a review of information from the Alabama Department of Public Health's (ADPH) Online Reporting System, the facility policies titled ABUSE POLICY/REPORTING ABUSE, and Medication Administration the facility failed to ensure Resident Identifier (RI) #324 and RI #329 were free from misappropriation of property when the resident's controlled substances were unable to be accounted for after Licensed Practical Nurse (LPN) #31's shift from 6:00 PM on 07/14/2024 to 6:00 AM on 07/15/2024. Specifically, LPN #31 signed RI #324's Controlled Drug Record for Lorazepam indicating that she removed a tablet. RI #324's Medication Administration Record (MAR or EMAR) revealed that the medication was not administered. During medication count back of LPN #31's cart, one of RI #329's Gabapentin was missing and was not documented as administered on RI #329's MAR. This deficient practice affected Resident Identified (RI) #324 and RI #329, two of 19 residents reviewed for misappropriation of controlled medications, and affected one of two medications carts on the East Hall. 2) The facility further failed to ensure RI #6 was free from misappropriation of his/her personal funds by Certified Nursing Assistant (CNA) #36 . This deficient practice affected RI #6 one of one resident sampled for misappropriation of personal funds. This deficiency was cited as a result of the investigation of a facility reported incident/complaint/report number AL00048347 and AL00048461. Findings Include: The facility policy titled ABUSE POLICY/REPORTING ABUSE,, with a revision date of 03/2022, revealed the following: . Procedure . Resident have the right to be provided an environment free of personal abuse, neglect, mistreatment, injuries of unknown source, and misappropriation of resident's property . The facility policy titled Medication Administration dated November 2024, revealed the following: Policy: Medications are administrated by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Policy Explanation and Compliance Guidelines: . 20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	21. If medication is a controlled substance, sign narcotic book . A review of an ADPH Online Facility Reported Incident dated 07/15/2024, revealed the following: . Incident Type . Select Category: . Abuse - Misappropriation of Resident Property . Incident Detail . Name of alleged perpetrator(s): (LPN #31) . Narrative summary of incident: A shift key nurse worked 6p - 6a 7/14-15. Received call at shift change 6 am of erratic behaviors from said nurse. She appeared to be under influence. Ambulance was called, she refused and sheriff had to be called to get her removed from property. Our DON (Former Director of Nursing #9) came in to do med count with the nurse and that's when we notice the narcotics missing. Action(s) taken by the facility in response to the incident. Authorities were notified to remove the nurse from the building. Review of the undated facility's investigative summary revealed: . This report is substantiated. There is misappropriation of resident property. Recap . The investigation revealed that the Administrator received a call regarding agency nurse (LPN #31) possibly under the influenced and displaying erratic behavior. Authorities were called and LPN #31 had to be escorted out. An immediate drug count was done . ADM filed a complaint with the Louisiana Board of Nursing as well as the Alabama Board of Nursing. A review of RI #324's Controlled Drug Record revealed a discrepancy of one Lorazepam tablet was identified on 07/15/2024. A review of RI #324's July 2024 MAR revealed that the 12:00 AM scheduled dose of Lorazepam was not administered on 07/15/2024 by LPN #31. A review of RI #329's Controlled Drug Record revealed LPN #31 signed that she removed one Gabapentin 200 mg tablet on 07/14/2024 at 8 PM. A review of RI #329's July 2024 MAR revealed that the 9:00 PM scheduled dose of Gabapentin was not administered by LPN #31 on 07/14/2024. Unsuccessful attempts were made to contact LPN #31 during the survey. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/04/2025 at 4:56 PM an interview was conducted with LPN #17 who said she counted the controlled medications with the Former DON #9. LPN #17 said, there were missing narcotic medications. LPN #17 said she they counted the pills on the card and compared it to the narcotic control record. LPN #17 further said, they did not compare the count to the MAR (Medication Administration Record) to see if the residents had received his/her medication. On 04/05/2025 at 1:43 PM an interview was conducted with the Administrator (ADM). The ADM said it was reported to him there were missing narcotics, and the alleged missing narcotics were identified and reported to the police department. The ADM said the facility investigated and verified misappropriation of resident property. 2) On 07/26/2024 the State Agency (SA) received a Facility Reported Incident (FRI) alleging abuse and a suspected crime had been committed by CNA #36 who had used RI #6's check card to make purchases. The FRI alleged CNA #36 and RI #6 had been warned months ago about that being against policy. During a Medicaid review it was discovered RI #6's account was overdrawn, had multiple Cash App debits totaling $1172.00, RI #6 did not know what Cash App was, had not given permission for it, the county sheriff was notified of theft of property, CNA #36 was not on duty on that day, and was to be informed, suspended and terminated. RI #6 was admitted to the facility on [DATE] and readmitted on [DATE]. On 04/02/2025 at 9:42 AM RI #6 was interviewed and said, he/she became aware of the missing money when he/she attempted to withdraw money from the bank and discovered the account was overdrawn. RI #6 said, he/she reported this to the business manager and the Administrator, and the bank reimbursed the funds. An interview was conducted with the ADM on 04/05/2025 at 8:02 AM. The ADM was asked about the misappropriation of funds related to RI #6. The ADM said he became aware of the missing funds when it was reported by the business office manager. The ADM said, he notified the police department that day and resident contacted the bank regarding the overdrawn account and RI #6 wanted a statement from bank to see where the funds went. The ADM said, he asked the resident that day if he/she gave his/her personal debit card information to anyone and RI #6 said, he/she gave it to CNA #36, who worked at the facility. The ADM said, the facility did not refund the money because the bank refunded RI #6's money, plus the overdrafts. The ADM said, based on the banking checking account statements that showed CNA #36 had been removing the funds, allegation was substantiated, and CNA #36 was automatically terminated. A form titled EMPLOYEE SEPARATION NOTICE for CNA #36 with a termination date of 08/15/2024 documented CNA #36's last day worked was 07/25/2024 and misappropriation of resident's property. RI #6's bank statements documented 21 debits for a Cash App for CNA #36's first name from 05/23/2024 through 06/20/2024, totaling $1172.00.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on interviews, resident record reviews, review of a facility policy titled Abuse, Neglect and Exploitation, review of Facility Reported Incidents (FRIs) received by the State Agency, and review of the facility's investigative files, the facility failed to ensure an allegation of sexual abuse was reported to the State Agency within two hours. Specifically, on 01/13/2025 around 2:00 AM, Licensed Practical Nurse (LPN) #13 called the Administrator/Abuse Coordinator (ADM) and reported RI #20 had been witnessed nude from the waist down in RI #44's room, sitting on Resident Identifier (RI) #44's bed next to RI #44 caressing RI #44's hip and thigh. The ADM failed report the allegation of sexual abuse to the State Agency until three days later on 01/16/2025. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.12 Freedom from Abuse, Neglect and Exploitation at F609-Reporting of Alleged Violations. On 04/11/2025 at 5:26 PM, the ADM, the Director of Nursing (DON), the [NAME] President of Risk Management, the [NAME] President of Clinical Operations, and the Senior Regional Director of Clinical Operations were provided a copy of the IJ template and notified of the finding of immediate jeopardy and substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F609-Reporting of Alleged Violations. The IJ began on 01/13/2025 and continued until 04/14/2025 when the survey team verified onsite that corrective actions had been implemented. On 04/15/2025 the immediate jeopardy was removed, F609 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as the result of the investigation of complaint /report #AL00049904. The facility further failed to ensure allegations of abuse that did not rise to the jeopardy level were immediately reported to the abuse coordinator and to the State agency within two hours. The allegations involved RI #3, RI #42, and RI #219. 2.) On 08/27/2023, staff failed to immediately report an allegation of verbal abuse involving RI #3 and a staff member to the Administrator/abuse coordinator and to the State Agency within two hours. 3.) On 05/27/2024 when bruising was found to RI #3's finger at 8:30 AM, the facility failed to immediately report the injury of unknown origin to the State Agency within two hours. 4.) On 05/20/2024, staff did not immediately report to the Administrator/abuse coordinator an allegation of physical abuse involving RI #219 and RI #42. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Four of 27 residents sampled for abuse were found to have been affected due to late reporting of abuse allegations as determined by the investigations of facility reported incident (FRI)/complaint/report numbers AL00049904, AL00045410, AL00047974, and AL00047903. Findings include: Cross-reference F600, F835, and F867. Review of the facility's policy titled, Abuse, Neglect and Exploitation, with an implemented date of 11/16/2024, and a revised date of 11/18/2024, revealed: Policy: . VII. Reporting/Response A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency . and all other required agencies . within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . 1.) On 01/16/2025 at 01:30 PM, the State Survey Agency received an initial report from the facility regarding an allegation of sexual abuse between RI #20 and RI #44 that occurred on 01/13/2025 at approximately 2:00 AM. According to this initial report, the accusation of sexual assault was reported to the Administrator via resignation letter. The facility investigative file contained a handwritten witness statement dated 01/13/2025, signed by LPN #13 who witnessed the abuse, which documented . went to answer the light as nurse was approaching the room she was startled to see RI #20 without a brief sitting in the bed with RI #44 looking at him/her and caressing his/her hip and thigh. Administrator . was immediately called . Surveyors attempted and were unable to reach LPN #13 for interview during the survey. An interview was conducted with the Administrator/Abuse Coordinator (ADM) on 04/03/2025 at 3:30 PM. The ADM said on 01/13/2025 around 2:00 AM LPN #13 called him and reported the incident involving RI #20 and RI #44. The ADM said LPN #13 reported that she observed RI #20 sitting on the side of RI #44's bed naked from the waist down while touching RI #44's waist and thigh. The ADM said based on the information provided by LPN #13 at the time, the ADM concluded that he did not believe sexual abuse had occurred. The ADM said, on 01/16/2025, LPN #13 submitted a resignation email alleging that the facility had attempted to conceal sexual abuse and claimed that what she witnessed on 01/13/2025 was sexual abuse. When asked about the appropriate timeframe for reporting allegations of abuse to the state agency, the ADM stated that it should be done within two hours. When the ADM was questioned whether this particular incident warranted a report within that timeframe, he maintained that it did not, as he did not initially perceive it as abuse based on the information received from LPN #13. The ADM said if LPN #13 said RI #20 was masturbating or had an erection he would have reported the incident immediately. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**********

On 04/15/2025, the facility submitted an acceptable removal plan, which documented:

1. Immediate action(s) taken for the resident(s) found to have been potentially affected include:

a. The facility failed to ensure an allegation of sexual abuse was reported to the State Agency within two hours. Specifically, on 01/13/2025 around 2:00 AM, LPN #13 called the Administrator/Abuse Coordinator and reported RI #20 had been found in RI #44's room, sitting on RI #44's bed next to RI #44. RI #20 was nude from the waist down and was caressing RI #44's hip and thigh. The ADM failed to immediately identify sexual abuse and report timely. RI #44 does not have the capacity to consent. The allegation of sexual abuse was not reported to the SA until 3 days later on 01/16/2025.

b. Allegation was reported to Administrators, ADPH, law enforcement, physician, family, ombudsman 01/16/2025

c. On 04/11/2025, the [NAME] President of Risk Management conducted an in-service for the Administrator and Director of Nursing covering all types of abuse and the facility's responsibility to ensure all allegation are reported timely to the State Agency.

2. Identification of Other Residents Having the Potential to Be Affected

a. All residents involved in an abuse allegation

3. Actions Taken / Systems to Be Put into Place to Reduce the Risk of Future Occurrences

a. The [NAME] President of Risk Management reviewed all facility-initiated reports of abuse and confirmed that all incidents were reported timely. No additional incidents were identified as having been unreported or reported outside of the required timeframe.

b. On 04/12/2025, the [NAME] President of Risk Management and the Regional Nurse Consultant provided one-on-one in-service training to the Administrator and Director of Nursing on the facility's Abuse Policy. This policy emphasizes that all residents have the right to be free from sexual abuse, outlines how to identify abuse, and mandates immediate protection of residents when abuse is suspected, as well as reporting to state agency within the mandated time frame, and notification to Ombudsman, family, physician, and law enforcement.

c. On 04/12/2025, a QAPI meeting was completed with the Administrator to ensure understanding of the Administrator's responsibility in implementing and enforcing facility policies. Moving forward, the Regional Nurse Consultant or the Regional Director of Operations will review and sign off on all facility reportable investigations, including those related to sexual abuse. This sign-off will verify that investigations are conducted in compliance with the facility's Abuse/Sexual Abuse Policy, QAPI Policy, Behavioral Health Services Policy, and Wandering Policy, and that all required procedures are properly implemented and followed.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. The facility investigative checklist was implemented on 4/12/25 as a guide on conducting abuse / sexual abuse investigations. Administrator (Abuse Coordinator) was in-serviced on 4/12/25 by VP of Risk Management on this form. This checklist will be completed by the abuse coordinator and verified for every reportable incident including sexual abuse investigations. Facility requests for IJ removal plan to be effective on 4/15/25 ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/14/2025. 4.) Cross reference F600 On 05/20/2024 at 6:52 AM the State Agency received a Facility Reported Incident (FRI) alleging physical abuse occurred at 12:00 AM on 05/20/2024, between roommates, when RI #219 told RI #42 to quit cussing and RI #42 got out of bed and assaulted RI #219 resulting in one having a bruise and the other having a cut. The FRI documented the ADM had been made aware of the allegation at 5:00 AM, about five hours after the abuse had occurred. On 04/10/2025 at 5:58 PM, an interview was conducted with ADM. The ADM stated he was notified by the FDON #29 of the incident involving RI #42 and RI #219. The ADM said, the FDON #29 said she heard voices getting loud in the room, she entered the room and found RI #42 standing beside RI #219's bed pushing RI #219's head down in the pillow. The ADM said, the FDON #29 separated the residents. When asked if residents had any injuries, the ADM said RI #219 had a bruise to the left elbow and RI #42 had a scratch below the left eyes, skin tear to the left elbow and a skin tear to the right upper arm. The ADM said, the incident occurred at 12:00 AM but was not reported until 6:52 AM, so it was not reported within the two-hour time frame. The FDON was contacted during the survey on 04/07/2025 at 3:40 PM and asked about the abuse incident, but she said she had only worked at the facility three months and she did not remember the residents or the incident. 2.) On 08/29/2023 at 6:15 AM the State Agency received a Facility Incident Report (FRI) alleging verbal abuse had occurred when a Housekeeper (HK) #30 removed a tray from RI #3's room and was overheard in the hallway saying old bitch, by Certified Nursing Assistant (CNA) #21. The FRI documented the date and time of the alleged incident was 08/27/2023 at 8:00 AM and the date and time when the Administrator (ADM) was notified of the incident was 08/28/2023 at 9:30 AM. RI #3 was admitted to the facility on [DATE] with diagnoses to include Dementia with Behavioral Disturbances, Restlessness and Agitation, Age-Related Physical Debility, and Hypertension. RI #3's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 08/16/2023 documented a Brief Interview for Mental States (BIMS) score of four out of fifteen which indicated severe cognitive impairment. RI #3 required extensive assistance with bed mobility and required total assistance with bathing and dressing. (continued on next page)

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	015406	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arabella Health & Wellness of Grand Bay	13750 Highway 90 West Grand Bay, AL 36541

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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 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of RI #3's comprehensive care plan with an implementation date of 02/08/2023 revealed . RI #3 has behavior indicators . aggressive behaviors . hitting/ pinching .yells out instead of utilizing call light . also taps/bangs (his/her) fingers on (his/her) bedside at times to get staff attention . On 04/08/2025 at 5:42 PM an interview was conducted with the ADM regarding the FRI. The ADM said the allegation of abuse was reported to the State Agency on 08/29/2023 at 6:15 AM and the incident occurred on 08/27/2023 at 8:00 AM. When asked why the incident was reported late, the ADM said, he did not know why it was reported late. The ADM, said the previous DON completed the investigation/report, and he was unaware of the incident occurred. When asked if the report was submitted within the required two-hour time frame, the ADM said no. 3.) On 05/27/2024 at 5:39 PM the State Agency received a FRI alleging an Injury of Unknown Source involving RI #3 occurred that morning at 8:30 AM when bruising of the middle finger was discovered. A CNA notified the charge nurse Registered Nurse (RN) #14 of bruising to RI #3's middle finger. RN #14 then notified the DON (Former DON #29) of suspected a fracture and she ordered an X-ray, the Family was notified, and results were obtained at 4:30 PM with fracture to the middle finger. On 04/08/2025 at 3:08 PM an interview was conducted with the Administrator (ADM). The ADM said he was notified of the incident on 05/27/2024 by the Former Director of Nursing (FDON #29) at 10:00 AM. The ADM said he made the report to the state agency when the results came back regarding the fracture. The ADM said part of his job responsibilities as Abuse Coordinator was to report any abuse allegations within two hours.

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of a facility policy titled Abuse Neglect and Exploitation the facility failed to conduct a thorough investigation to ensure appropriate corrective actions were taken to prevent recurrence following an allegation of sexual abuse that occurred on 01/13/2025, involving Resident Identifier (RI) #20 and RI #44. On 01/13/2025 at approximately 2:00 AM, Licensed Practical Nurse (LPN) #13 responded to a call light from RI #44's room and found RI #20 naked from the waist down, seated on RI #44's bed caressing RI #44's hip and thigh. The facility failed to ensure the investigation included and focused on whether abuse had occurred, the extent, and cause. The facility's investigation did not include when RI #20 entered RI #44's room, the duration of RI #20's presence in the room, details regarding what LPN #13 had witnessed, and RI #20's history of known behaviors of masturbation, watching others undress, and wandering. Additionally, the facility failed to determine when the residents were separated and how RI #44 and RI #20 were monitored immediately following the incident. The facility also failed to obtain thorough statements from staff who were working at the time. Further, the facility failed to ensure video recordings from the night of the incident were preserved and/or that a summary of the footage was documented. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death. The Immediate Jeopardy (IJ) was related to 483.12 Freedom from Abuse, Neglect, and Exploitation. On 04/11/2025 at 5:26 PM, the Administrator (ADM), the Director of Nursing (DON), the [NAME] President of Risk Management, the [NAME] President of Clinical Operations, and the Senior Regional director of Clinical Operations were provided a copy of the IJ template and notified of the finding of immediate jeopardy and substandard quality of care in the area of Freedom from Abuse, Neglect, and Exploitation at F 610-Investigate/Prevent/Correct Alleged Violations. The IJ began on 01/13/2025 and continued until 04/14/2025 when the survey team verified onsite that corrective actions had been implemented. On 04/15/2025 the immediate jeopardy was removed, F610 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. The facility further failed to ensure allegations of injuries of unknown source that did not rise to the jeopardy level were thoroughly investigated, enabling the facility to correctly identify root causes and develop action plans for prevention of abuse and resident injury in the facility. 2.) On 05/27/2024 the facility failed to thoroughly investigate an injury of unknown origin to determine the root cause and rule out abuse, for RI #3, a resident who was found to have a bruised and fractured finger. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3.) On 07/15/2024 the facility failed to thoroughly investigate an injury of unknown origin to determine the root cause and rule out abuse, for RI #169, a resident who was found to have a bruised, swollen, and fractured foot/ankle. These failures affected RI #44, RI #3, and RI #169, three of 27 residents sampled for abuse and were cited as a result of the investigation of complaint/report numbers AL00049904, AL00047974, and AL00049295. Findings include: Cross-Reference F600, F609, F740, F835, and F867. Review of the facility's policy titled, Abuse, Neglect and Exploitation, with an implemented date of 11/16/2024, and a revised date of 11/18/2024, revealed: Policy: . V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include; 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation . 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved person, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation . On 01/16/2025 at 01:30 PM, the State Survey Agency received an initial report from the facility regarding an allegation of sexual abuse between RI #20 and RI #44 that occurred had on 01/13/2025 at approximately 2:00 AM. According to this initial report, the accusation of sexual assault was reported to the administrator via resignation letter. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility investigative file contained a handwritten Nurse's Note dated 01/13/2025, signed by LPN #13 who witnessed the abuse, which documented . went to answer the light as nurse was approaching the room she was startled to see RI #20 without a brief sitting in the bed with RI #44 looking at him/her and caressing his/her hip and thigh. As RI #20 and the nurse made eye contact he/she was startled and immediately stopped touching RI #44. Nurse ran to the day room looking for RI #20's CNA and some assistance. RI #20 was immediately removed from RI #44's room . Head to toe assessments were immediately performed on RI #20 and RI #44. No broken skin, discolorations, or bruises were noted (RI #20) was immediately removed from (RI #44)'s room and returned to (his/her) room. (RI #20) . room is across the hall from (RI #44) . (ADM) was immediately called. Surveyors attempted and were unable to reach LPN #13 for interview during the survey. Further review of LPN #13's handwritten Nurse's Note dated 01/13/2025 revealed . CNA's were interviewed nurse determined no CNAs assigned were at fault but all were asked to provide statements. The facility's investigative file contained a Nurse's Note with CNA #23 dated 01/13 at 3:10 AM. CNA #23's note documented that she was the CNA assigned to RI #44's care and During the time of the incident . I was on lunch break. I was informed of what happened when I returned . The facility's investigative file contained a Nurse's Note dated 01/13/2025 that documented I (CNA #12) can not go into (RI #44's roommates) room . So I did not answer (his/her) light! . I did not know where (RI #20) was at or that (he/she) had entered (RI #20)'s room! The facility's investigative file contained a Nurse's Note dated 01/13/2025 that documented Around 2:30 AM, I was notified by primary nurse that she need help with a resident. Head to toe assessment performed. Proceed to move (male/female) resident to another room away from resident. Signed by LPN #22. No other interviews or statements from staff were included in the facility's investigation. A review of a document titled Investigation Conclusion dated 01/24/2025 signed by the Administrator documented: . The incident/allegation of sexual abuse is unsubstantiated. The report was generated after the nurse resigned based on the verbiage of her resignation letter. RI #20 was found sitting on the edge of RI #44's bed naked from waist down. When the nurse entered the room, she witnessed RI #20 touching RI #44 on the thigh and hip. RI #20 has wandering tendencies but has never had any issues nor sexual tendencies with any other male or female residents. RI #44's brief was secure and intact and no sign of displacement. RI #44 is non-verbal and RI #20 has severe short term memory. RI #20 was questioned and denied the allegations . (RI #20) was placed one-on-one . The facility form titled Resident Observation/Monitoring Tool dated 01/13/2025 had 1-1 observations and RI #20's name handwritten at the top. The tool documented observations began at 6:00 AM on 01/13/2025. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's investigative file revealed that the facility's investigation did not include the time at which RI #20 accessed RI #44's room, the length of time RI #20 was in the room, nor details regarding exactly what LPN #13 had witnessed. The facility's investigative file did not include when the residents were separated and how and by whom RI #20 was monitored immediately following the incident. The investigation also did not include adequate details and comprehensive statements from the staff present at the time, who possessed relevant information regarding the response and protection of RI #44 and other residents. Statements included in the investigative file were documented on Nurse's Notes and dated 01/13/2025. During an interview with CNA #25 on 04/08/2025 at 2:17 PM, she said LPN #13 told her that RI #20 was found in RI #44's room sitting on RI #44's bed on top of the covers with his/her hand on RI #44's hip and a massaging motion was observed. CNA #25 said RI #20 was moved to the [NAME] Wing and CNA #12 provided one-on-one monitoring. A statement dated 04/06/2025 signed by CNA #41 revealed that he did not see RI #20 in RI #44's room because he was working on the other end. CNA #41 said LPN #13 came down to this end and called the ADM. The statement indicated that CNA #12 was sitting with RI #20 after RI #20 was moved to his unit. On 04/09/2025 at 6:10 PM during an interview with CNA #12, she said LPN #13 told her that RI #20 had been moved to the [NAME] Wing and she did not see him/her again that night. CNA #12 said she did not provide one-on-one care to RI #20 on 01/13/2025. An interview was conducted with the Administrator/Abuse Coordinator (ADM) on 04/03/2025 at 3:30 PM. The ADM stated LPN #13 gave two accounts, in one note she said she immediately separated the residents and in another she said she went and got help. A follow-up interview was conducted with the Administrator on 04/09/2025 at 12:21 PM. The ADM said based on the facility's investigation, he did not know the length of time that RI #20 was in RI #44's room. He said the investigation found that RI #20 got up and was found in RI #44's room with no clothes on from the waist down, touching RI #44's leg and a staff member witnessed this when she entered the room. When the video footage was requested during the survey, the facility provided a document that indicated that there was no video footage of the incident that occurred on 01/13/2025 because The footage was stored on a hard drive that [NAME] is unable to access. Additionally, it is believed that the video system operates on a loop that records over previous footage, which may have resulted in the footage being overwritten. The document was signed by the ADM. ********** The facility submitted an acceptable removal plan, which documented: F610 Removal Plan 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. The facility failed to conduct a thorough investigation into a reported allegation of sexual abuse that occurred on 01/13/2025. The facility failed to determine when RI #20 entered RI #44's room and the duration of RI #20's presence in the room. Additionally, the facility failed to determine whether LPN #13 who observed the incident, took immediate action to protect RI #44, failed to collect details and thorough statements from staff who were working at the time and had information about the response and protection of RI #44. b. On 04/11/2025, the [NAME] President of Risk Management conducted an in-service for the Administrator and Director of Nursing addressing all types of abuse and the facility's responsibility to ensure resident safety. The training emphasized the importance of collecting and documenting detailed, thorough statements from all staff involved or present during an incident, including those with knowledge of the response and protective actions taken. It also included guidance on reviewing staff time sheets to ensure all potentially involved personnel or personnel with knowledge of the incident or contributing factors are identified and interviewed, with a focus on asking clarifying follow-up questions rather than relying solely on written statements. Investigative check list was implemented to ensure a through investigation is complete. The Tool was reviewed with the DON and Administrator to ensure understanding, regional nurse consultant was on site and completed an investigation with the DON and admin to verify understanding. Additionally, the Abuse Coordinator was trained to investigate for root cause and conduct a root cause analysis for each incident to identify contributing factors and implement appropriate corrective actions; and to notify Regional Nurse Consultant or the Regional Director of Operations of the incident occurrence. 2. Identification of other residents having the potential to be affected: a. This had the potential to affect all residents. Regional nurse consultant reviewed the complete investigation files of the facility reported incidents using the Investigation checklist form to identify other incidents of sexual abuse reported since 1/1/2025. None were identified. This was completed on 4/12/25. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences include: a. On 04/12/2025, a QAPI meeting was completed with the Administrator to ensure understanding of the Administrator's responsibility in implementing and enforcing facility policies. The Administrator will notify Regional Nurse Consultant or the Regional Director of Operations of the incident occurrence. They will review and sign off on the Investigation check list prior to submission of the 5-day conclusion. This sign-off will verify that investigations are conducted in compliance with the facility's Abuse/Sexual Abuse Policy, QAPI Policy, Behavioral Health Services Policy, and Wandering Policy, and that all required procedures are properly implemented and followed. b. The facility investigative checklist was implemented on 4/12/25 as a guide on conducting abuse / sexual abuse investigations. Administrator (Abuse Coordinator) was in-serviced on 4/12/25 by VP of Risk Management. This checklist will be completed by the abuse coordinator and verified for every reportable incident including sexual abuse investigations. Facility requests IJ removal plan to be effective on 04/15/2025. ********** (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/14/2025. 2.) On 05/27/2024 at 5:39 PM the State Agency received a Facility Incident Report (FRI) alleging an injury of unknown source for RI #3 when a CNA notified the charge nurse of bruising to the middle finger approximately 8:30 AM and the Charge nurse then notified the (FDON) and she ordered an X-ray. The Family was notified, results were obtained at 4:30 PM with fracture to RI #3's middle finger; actions taken included immediately staff started investigation and notified family, getting witness statements and suspending CNA's that had contact with RI #3. RI #3 was admitted to the facility on [DATE] with diagnoses to include of Dementia with Behavioral Disturbances, Restlessness and Agitation, Age-Related Physical Debility, Primary Hypertension. A review of RI #3's comprehensive care plan with an implementation date of 02/08/2023 revealed . RI #3 has behavior indicators . aggressive behaviors . hitting/ pinching . yells out instead of utilizing call light . also taps/bangs (his/her) fingers on (his/her) bedside at times to get staff attention . A review of a document titled Mobile Images for RI #3 dated 05/28/2024 revealed: . PROCEDURE: X- RAY -RIGHT HAND . TECHNIQUE: 2 view (s) of the hand . FINDINGS: There is undisplaced fracture of distal metaphysics of middle phalanx of 3rd digit seen with sclerosis and soft tissue thickening. No callus formation seen. Reduced bone density seen . A review of RI #3's nursing progress notes dated 05/27/2024 from Former Director of Nursing (FDON) #29 revealed, . at 9:30 AM the charge nurse reported to this writer that resident may have a fracture to middle finger of right hand. (His/her) finger is bruised and swollen . The facility investigative file contained a handwritten statement signed by CNA #20 documented: . I noticed (his/her) arm and finger was (bruised) and swollen, I then proceeded to let the nurse know . On 04/07/2025 at 4:59 PM CNA #20 was asked about her handwritten statement in the facility investigative file. CNA #20 said, that day 05/27/2024, RI #3 was able to speak clearly, and told CNA #20, she hurt me and CNA #20 reported it. On 04/08/2025 at 10:05 AM the RR was asked about the incident with RI #3's finger. The RR said, that day RI #3 was distraught by it all, RI #3's speech was better so the RR spoke with RI #3 about it and RI #3 told the RR the aide hurt (him/her), but RI #3 did not know her name. The RR said, that day RI #3 was sobbing uncontrollably and grabbed her crying and upset. The RR stated she was not satisfied with the investigation outcome because no one ever told her anything other than they could not really determine what happened. The RR felt RI #3 had been physically and mentally abused. The facility investigative file for RI #3 did not contain interviews with staff who may have had knowledge of occurrences that could have caused or contributed to the injury of bruising and fracture prior to 05/26/2024 and it did not contain documentation that a skin or body assessment was completed on RI #3 after the injury was identified. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility investigative file contained a typed document titled with RI #3's name and dated 05/26/2024, that was not signed and did not contain information about who created the document included the following: . The RP (Resident Representative) came in around (1:00 PM) to check on (him/her) and gave (FDON #29) additional information regarding the situation. (RI #3) gave information regarding the situation. The facility investigative file contained a sheet of white paper, unsigned and undated, with handwritten notes that included the following documentation: . (1:00 PM) . (RI #3's RR name) spoke to (CNA #20) . (4:30 PM) . spoke (with) (RI #3's RR) . says (he/she) was mishandled said a black woman was ugly to me I don't like you because you are white, she scratched me said, don't let her come back in here again. On 04/08/2025 at 3:08 PM an interview was conducted with the Administrator (ADM) who said he was notified on 05/27/2024 at 10:00 AM by FDON #29 of RI #3's bruising of the middle finger. The ADM said notifications were made, an X-Ray was ordered, and an investigation initiated. The ADM said interviews from staff who directly worked with RI #3 the day before the injury were obtained as part of the investigation. The ADM said staff denied having knowledge of anything occurring that could have caused an injury, and therefore the investigation was unsubstantiated. When asked why interviews were not obtained from staff who worked with RI #3 days prior to when injury was identified, the ADM said he only thought to interview direct care staff who worked with RI #3 the day before on 05/26/2024. The ADM said, he did not get interview with some nurses and CNAs who worked on 05/26/2024. The ADM said, he did not speak with or interview other residents to find out anything they might know. When asked about the note in the investigative file about CNA #20 and RI #3's RR and RI #3 being mishandled. The ADM said, he did not know where the note came from, and he was not aware of that information. The ADM continued to say he did not know where it came from or who wrote it because there was no signature. The ADM said, it was important to the investigation, and he should have been aware of the note. The ADM said, there was not any documentation of discussing the results of the investigation with the family. The ADM said, he did not see evidence of a body audit assessment after the incident until September 2024. The ADM said, the incident was discussed with the team in the morning meeting the next day but based on what he now knew, the allegation involving RI #3 was not thoroughly investigated. On 04/11/2025 at 10:41 AM during a follow-up interview the ADM, he was asked how was the facility able to determine the appropriate corrective action if an investigation did not include all witness statements. The ADM said, it would be hard to determine an appropriate corrective action plan. 3.) On 07/15/2024 at 3:21 PM the State Agency (SA) received a Facility Reported Incident (FRI) alleging Injury of Unknown Source involving RI #169 who had a large hematoma located on the right foot with swelling; actions taken by the facility in response to the incident included notified family, called for an X-ray, and assessed for pain. RI #169 was admitted to the facility on [DATE] with diagnoses to include Myocardial Infarction, Hypertension, Atrial Fibrillation, and Kidney Failure. RI #169's Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/09/2024 documented a Brief Interview for Mental Status (BIMS) score of five out of 15 which indicated severe cognitive impairments and requirements of maximum assistance for toileting, bathing and dressing. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of RI #169's Departmental Notes, dated 07/15/2024 at 10:21 AM, revealed called to resident room per CNA, upon assessment large hematoma noted to right foot with swelling. Range Of Motion Within Normal Limits, states (he/she) does not know what happened to (his/her) foot . A review of a x-ray results titled Mobile Images for RI #169, dated 07/15/2024 revealed . PROCEDURE: Right Foot, Complete, 3 Views HISTORY: Injury, swelling FINDINGS: Faint lucency across right 4th and 5th metatarsal heads noted . IMPRESSIONS: Suspect hairline nondisplaced fracture lucency across right 4th and 5th metatarsal heads, faintly visualized nondisplaced fracture lucency noted articular base of 5th metatarsal, extensive area of soft tissue swelling over foot and ankle noted. On 04/10/2025 at 11:27 AM an interview was conducted with the ADM who said he was notified of RI #169's injury of unknown origin on 07/15/2024. The ADM said RI #169 was interviewed and did not know how the injury occurred. The ADM said X-rays were ordered and revealed fractures, interventions were put in place for a boot and non-weight bearing status, an investigation was initiated, and interviews were conducted with staff. During the interview the facility investigative file for RI #169 was reviewed and revealed: 1) no documentation of staff interviews or any staff who may have had knowledge of occurrences that could have caused or contributed to the injury of bruising and fracture. 2) no documentation that a skin or body assessment was completed after the injury was identified. The ADM was asked about the documentation into RI #169's investigative file. The ADM said he did not know where the documentation was, and that the evidence of interviews should be in the file. When asked if RI #169's injury of unknown origin was thoroughly investigated, the ADM said based on the lack of documentation, no.

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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** Based on interview, record review and review of the Center for Medicare and Medicaid (CMS Center) Long-Term Care Resident Instrument 3.0 Manual, the facility failed to ensure Resident Identifier (RI) #53's Minimum Data Set (MDS) assessment dated [DATE] was coded accurately to reflect RI #53 had a Preadmission screening and Resident Review (PASRR) Level II. This deficient practice affected one of 20 sampled residents whose MDS was reviewed. Findings include: Review of Center for Medicare and Medicaid (CMS) Long- Term Care Resident Instrument 3.0 Manual, dated October 2024, revealed the following: A 1500 Preadmission Screening and Resident Review (PASRR) . Code 1. Yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition. RI #53 was admitted to the facility on [DATE] and had diagnoses to include Depression, Adjustment Disorder with Mixed Disturbances of Emotions and Conduct, and Psychotic Disorder with Delusions due to known Physiological Condition with Depressive Features. A review of RI #53's medical record revealed a diagnosis of Schizophrenia was added on 02/16/2024. A review of RI #53's PASRR Level II Service Determination completed on 05/31/2024 revealed . Section I: Diagnosis . X (marked for) Serious Mental Illness (MI) specify: Schizophrenia . RI #53's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 09/17/2024 was marked No for the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?. On 04/09/2025 at 11:59 AM an interview was completed with Social Services staff (SS) #5 regarding RI #53's Level II. The SS confirmed RI #53 was a Level 11 as of 05/31/2024. The SS was asked if RI #53 was coded as a Level II in the MDS dated [DATE], the SS said no. When asked should RI #53 have been coded for Level II, the SS said yes. The SS said the importance of coding accuracy is for tracking purposes and to ensure residents in the facility who have mental health diagnoses are receiving appropriate mental health services.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, the Alabama Department of Public Health Online Incident Reporting System, review of a facility investigative file, and review of a facility policies titled ERRORS IN CONTROLLED SUBSTANCE COUNTS / DISCREPANCIES and Medication Administration the facility failed to ensure Licensed Practical Nurse (LPN) #31 followed standard of practice when she failed to document the administration of controlled medications during the 6:00 PM (07/14/2024) to 6:00 AM (07/15/2024) shift per facility's policy and standards of practice. Specifically, LPN #31 failed to document the removal of controlled medications on the residents' Controlled Drug Records when she documented the medications as administered on the Electronic Medication Administration Record (EMAR or MAR). The deficient practice affected Resident Identifiers (RI) # 6, RI #20, RI #327, RI #328, RI #319. Further, LPN #31 failed to administer RI #319's Norco on 07/15/2024 at 1:00 AM, RI #22's Gabapentin on 07/14/2024 at 8:00 PM, and RI #330's Tramadol on 07/14/2024 at 8:00 AM and 07/15/2024 at 5:00 AM. Further, LPN #31 signed RI #324's Controlled Drug Record for Lorazepam indicating that she removed a tablet and she did not document that the medication was administered on the residents' EMAR. During medication count back of LPN #31's cart, one of RI #329's Gabapentin was missing and was not documented as administered. This affected 9 of 19 residents reviewed for misappropriation of controlled medications, and affected one of two medications carts on the East Hall. This was cited as a result of the investigation of complaint/report number AL00048347. Findings include: On 07/15/2024 the State agency received a report from the facility on the Online Incident Reporting System. The report documented the incident type as Abuse-Misappropriation of Resident Property. The narrative summary of the incident documented: . A shift key nurse worked 6p-6a 7/14-15. Received call at shift change 6 am of erratic behavior from said nurse. She appeared to be under the influence. Ambulance was called, she refused, and sheriff had to be called to get her removed from property. Our DON (Former Director of Nursing #9) came in to do med count with the nurse and that's when we notice the narcotics missing . The date and time of the occurrence was reported to be 07/15/2024 at 10:01 AM. The facility policy titled ERRORS IN CONTROLLED SUBSTANCE COUNTS / DISCREPANCIES, with a revision date of 03/2022, revealed the following: . PROCEDURE . This procedure must be done by . LICENSED NURSES Document on the . narcotics records. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation must include: Date and time . . nurses complete signature and title . The facility policy titled Medication Administration dated November 2024, revealed the following: Policy: Medications are administrated by licensed nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Policy Explanation and Compliance Guidelines: . 20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR. 21. If medication is a controlled substance, sign narcotic book . (1) RI #6 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #6 had diagnoses that included Hereditary and Idiopathic Neuropathy. A review of RI #6's July 2024 Order Summary Report (Physician Orders) revealed an order for Gabapentin 300 mg (milligrams) 1 capsule by mouth 2 times a day for pain. A review of RI #6's Controlled Drug Record revealed that a discrepancy of 1 capsule of Gabapentin 300 mg was identified on 07/15/2024 and LPN #31 had not signed that she removed a capsule on 07/14/2024. A review of RI #6's July 2024 MAR revealed that LPN #31 documented RI #6's 8:00 PM dose of Gabapentin 300 mg as administered on 07/14/2024. (2) RI #20 was admitted to the facility on [DATE]. RI #20 had diagnoses that included Epilepsy and Muscle Weakness (Generalized). RI #20's July 2024 Physician Orders revealed an order for Phenobarbital 32.4 mg, 4 tablets (129.6 mg) by mouth at bedtime for seizures. A review of RI #20's Controlled Drug Record revealed a discrepancy of 4 tablets of Phenobarbital 32.4 mg was identified on 07/15/2024. LPN #31 had not signed that she removed any tablets on 07/14/2024. A review of RI #20's July 2024 MAR revealed that the LPN #31 documented the 8:00 PM dose Phenobarbital 32.4 mg 4 tablets as administered on 07/14/2024. (3) RI #327 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #327 had diagnoses that included Right Upper Quadrant Pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of RI #327's July 2024 Physician Orders revealed an order for Tramadol HCL 50 mg, 1 tablet by mouth every 6 hours PRN for pain. A review of RI #327's Controlled Drug Record revealed a discrepancy of one Tramadol 50 mg was identified on 07/15/2024. LPN #31 had not signed that she removed a tablet on 07/14/2024. A review of RI #327's July 2024 MAR revealed LPN #31 documented that she administered Tramadol to RI #327 on 07/14/2024. (4) RI #328 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #328 had diagnoses that included Chronic Pain Syndrome. A review of RI #328's July 2024 Physician Orders revealed an order for Percocet 10-325 mg, 1 tablet by mouth two times a day PRN (as needed) for pain. A review of RI #328's Controlled Drug Record revealed a discrepancy of 4 Percocet 10 mg tablets was identified on 07/15/2024. LPN #31 had not signed that she removed a capsule on 07/14/2024. A review of RI #328's July 2024 MAR revealed LPN #31 administered Percocet to RI #328 on 07/14/2024 at 9:38 PM. (5) RI #319 was admitted to the facility on [DATE] and had diagnoses that included Chronic Pain Syndrome and Rheumatoid Polyneuropathy with Rheumatoid Arthritis of Multiple Sites. A review of RI #319's July 2024 Physician Orders revealed an order for Hydrocodone-Acetaminophen (Norco) 10-325 mg, 1 tablet by mouth every 6 hours for pain. A review of RI #319's Controlled Drug Record a discrepancy of 1 Norco 10-325 mg tablets was identified on 07/15/2024 and LPN #31 had not signed that she removed a capsule on 07/14/2024. A review of RI #319's July 2024 MAR revealed that LPN #31 documented the 7:00 PM on 07/14/2024 dose of Norco as administered and did not document the 1:00 AM on 07/15/2024 dose as administered. (6) RI #22 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #22 had diagnoses that included Right Knee and Left Hip Pain. A review of RI #22's July 2024 Physician Orders revealed an order for Gabapentin 300 mg one tablet by mouth two times a day. A review of RI #22's Controlled Drug Record revealed LPN #31 did not remove Gabapentin on 07/14/2024. No discrepancy was identified. A review of RI #22's July 2024 MAR revealed that the 8:00 PM scheduled dose of Gabapentin was not administered on 07/14/2024. (7) RI #330 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #330 had diagnoses that included Nondisplaced Fracture of Right Tibial Spine and Chronic Pain Syndrome. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of RI #330's July 2024 Physician Orders revealed an order for Tramadol HCL 50 mg, 2 tablets by mouth three times daily for pain. A review of RI #330's Controlled Drug Record revealed LPN #31 did not sign the Controlled Drug Record that she removed any Tramadol 50 mg tablets and no discrepancy was identified. A review of RI #330's July 2024 MAR revealed the 8:00 PM dose of Tramadol was not administered on 07/14/2024 and the 5:00 AM dose was not administered on 07/15/2024. (8) RI #324 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #324 had diagnoses that included Anxiety and Insomnia. A review of RI #324's July 2024 Physician Orders an order for Lorazepam 1 mg per peg tube twice daily for Anxiety. RI #324's Controlled Drug Record revealed a discrepancy of one Lorazepam tablet was identified on 07/15/2024. LPN #31 had not signed that she removed a capsule on 07/14/2024. RI #324's July 2024 MAR revealed that the 12:00 AM scheduled dose of Lorazepam was not administered on 07/15/2024 by LPN #31. (9) RI #329 was admitted to the facility on [DATE] and readmitted on [DATE]. RI #329 had diagnoses that included Weakness. A review of RI #329's July 2024 Physician Orders revealed an order for Gabapentin 200 mg one tablet by mouth nightly. A review of RI #329's Controlled Drug Record revealed LPN #31 signed that she removed one Gabapentin 200 mg tablet on 07/14/2024 at 8 PM. A review of RI #329's July 2024 MAR revealed that the 9:00 PM scheduled dose of Gabapentin was not administered by LPN #31 on 07/14/2024. On 04/08/2025 and 04/09/2025 unsuccessful attempts were made to contact LPN #31. Contained within the facility's investigative file was a Witness Statement, dated 07/15/2024, given by Former DON #9 (Director of Nursing). The following was documented: . Spoke with CNA (Certified Nursing Assistant) #11 @ 07:45 a.m. today. She stated that nurse on p.m. shift c/o headache twice during shift and @ 04:30 a.m. they noted her slumped over and was asleep . On 04/04/2025 at 4:56 PM an interview was conducted with LPN #17. LPN #17 said she counted the controlled medications with FDON #9. LPN #17 said there were missing narcotic medications. LPN #17 said she they counted the pills on the card and compared it to the narcotic control record. LPN #17 further said, they did not compare the count to the MAR to see if the residents had received his/her medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/05/2025 at 1:43 PM an interview was conducted with the Administrator (ADM). The ADM said it was reported to him on 07/15/2024 that there were missing narcotics, and the alleged missing narcotics were identified and reported to the police department. The ADM said LPN #17 and FDON #9 performed controlled drug/narcotic count after the incident. The ADM said the assigned charge nurse was responsible for documenting controlled medication on the MAR and/or Controlled Drug Record. When asked, what was the concern of not having the correct documentation on the MAR or the Controlled Drug Record, he said, we would not know what medicine had been given or the nurse who gave the medication. On 04/15/2025 at 12:33 PM the Consultant Pharmacist (CP) was interviewed. The CP was asked, what was the standard of practice nurses use when administering medications. The CP said, it was expected that nurses follow the facility's medication administration policy

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, resident record review, and review of a facility policy titled Behavioral Health Care Services, the facility failed to ensure residents with behaviors were managed and addressed to prevent and protect other residents from being abused, and to ensure other residents' safety and privacy was protected from residents with combative, aggressive, wandering, and sexual behaviors. 1.) Specifically, on 01/13/2025 during the night, at approximately 2:00 AM, Licensed Practical Nurse (LPN) #13 found Resident Identifier (RI) #20 in another resident's room, sitting on RI #44's bed, without clothing from the waist down, and caressing RI #44's hip and thigh. Facility staff had knowledge of resident masturbating, family members witnessed RI #20 masturbating, and a Behavioral Health (BH) note dated 01/14/2025 documented family had reported resident would masturbate in front of others. The facility failed to communicate these behaviors to ensure interventions were developed and implemented to ensure RI #20 was supervised in a manner to prevent abuse and protect residents in the facility. It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 443.40 Behavioral Health Services. On 04/11/2025 at 5:26 PM, the Administrator (ADM), the Director of Nursing (DON), the [NAME] President of Risk Management, the [NAME] President of Clinical Operations, and the Senior Regional director of Clinical Operations were provided a copy of the IJ template and notified of the finding of immediate jeopardy in the area of Behavioral Health at F740-Behavioral Health Services. The IJ began on 01/13/2025 and continued until 04/14/2025 when the survey team verified onsite that corrective actions had been implemented. On 04/15/2025 the immediate jeopardy was removed, F740 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficiency was cited as the result of the investigation of complaint/report number AL00049904. The following deficiencies did not rise to the level of IJ. 2) The facility failed to manage RI #31's behavior on 06/13/2024 when RI #31 was very agitated and attempted to slap one resident and later hit another resident, RI #20, in the back of the head. The facility failed to provide supervision and interventions to protect residents in the facility from abuse by RI #31 who was exhibiting verbal and physical behaviors against others. 3.) The facility failed to manage RI #59's behaviors on 08/14/2024 when RI #59 entered RI #325's room, initiated an altercation with RI #325, and took RI #325's babydoll. The facility failed to provide supervision and interventions to protect residents from being affected by RI #59's aggressive, combative, and wandering behaviors. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These deficiencies were cited as a result of the investigation of complaint/report number AL00048142 and AL00048960. These failures affected RI #44, RI #20, RI #31, RI #325, and RI #59, five of 41 sampled residents. Findings include: A facility policy titled Behavioral Health Care and Services with an implemented date of 11/2024 documented: Policy: It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning and well-being . Policy Explanation and Compliance Guideline: 1. Behavioral health encompasses a resident's whole emotional and mental well-being, . 3. The facility will ensure the necessary behavioral health care services are person-centered and reflect the resident's goals for care, while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice and safety . 7. The facility utilizes the comprehensive assessment process for identifying and assessing a resident's mental and psychosocial status and providing person-centered care. The assessment and care plan will include goals that are person-centered and individualized to reflect and maximize the resident's dignity, autonomy, socialization, independence, choice, and safety. Staff will: . b. Obtain history from medical records, the resident, and as appropriate the resident's family and friends regarding mental, psychosocial, and emotional health. f. Assess and develop a person-centered care plan for concerns identified in the resident's assessment. g. Share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes . h. Accurately document the changes, including frequency of occurrence and potential triggers in the resident's record. i. Ensure appropriate follow-up as needed. j. Discuss potential modifications to the care plan. k. Evaluate resident and care plan routinely to ensure the approaches are meeting the needs of the resident. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10. All facility staff, including contracted staff and volunteers, shall receive education to ensure appropriate competencies and skill sets for meeting the behavioral health needs of residents. Behavioral health training as determined by the facility assessment will include, but is not limited to, the competencies and skills necessary to provide the following: a. Person-centered care and services that reflect the resident's goals for care. 11. Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident . RI #20 was admitted to the facility on [DATE] with diagnoses to include Intracranial injury with loss of consciousness. RI #20's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/06/2024 documented the resident had a Brief Interview for Mental Status (BIMS) score of four out of 15, which indicted severe cognitive impairment. A review of RI #20's Care Plan Report revealed: . RI #20 has behavior indicators. (He/She) is sometimes aggressive toward peers and requires redirection. At risk for altercation, complications associated with behavior issues . start date 3/1/2024 . Status Active . When acute behaviors are noted, intervene promptly to manage/redirect . A review of RI #20's Comprehensive Care Plan submitted by the facility immediately following the survey revealed: . Behaviors will be identified and minimized or eliminated without causing harm to resident or staff during acute episode . with appropriate intervention . meds, redirection, diversional activities etc . The Care Plan included interventions and start dates including . (RI #20) has had episodes of being sexually inappropriate in the common areas of the facility. Staff is to redirect resident. Start Date 06/05/2024 . Further review of the Comprehensive Care Plan revealed that RI #20 had an intervention related to him/her wandering to roommates' side of room. The Care Plan did not include interventions to address RI #20 wandering into other residents' rooms. On 01/13/2025 LPN #13 documented that she witnessed RI #20 sitting on RI #44's bed. RI #20 was not wearing clothing from the waist down and was caressing RI #44's hip and thigh. RI #20's medical record included a Behavioral Health Progress Note signed by Family Nurse Practitioner (FNP) #40 dated 01/14/2025. The note documented: . History of Present Illness . Pt (patient) seen today for Initial televisit encounter for psychiatric evaluation and medication management. Resident seen today at the request of staff for inappropriate sexual behaviors . Staff reports that resident was found recently in another . residents room, sitting on the end of the bed, and rubbing (his/her) thigh. It was documented that (he/she) was indecently exposed from the waist down . Family has reported that (he/she) will masturbate in front of others. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(He/She) does not appear to be a threat to (himself/herself) or others at this time. Again, (he/she) does display cognitive impairments . TBI (traumatic brain injury). 1:1 sitter could be discontinued with close observation of patient while medications have the time to become efficacious. Examination . Judgement Fair to Poor . Treatment . 2. Inappropriate sexual behavior . Attempts to interview FNP #40 during the survey were unsuccessful. On 04/04/2025 at 2:25 PM an interview was conducted with Certified Nursing Assistant (CNA) #23 who reported she was assigned to provide care to RI #44 on 01/13/2025 when the incident occurred. CNA #23 said she saw RI #20 sitting on the side of his/her bed when she took RI #44 to the shower. CNA #23 said RI #20 was dressed and he/she was looking out the door which faced RI #44's room. CNA #23 said it did seem unusual because RI #20 was normally asleep. CNA #23 said she was unaware that RI #20 had any sexual behaviors such as self-stimulation or masturbation. CNA #23 said another staff told her that RI #20 had previously went into another resident's room, but she had not witnessed RI #20 wandering. On 04/09/2025 at 6:10 PM an interview was conducted with CNA #12 who was assigned to RI #20's care on 01/13/2025 when the incident occurred. CNA #12 was asked what type of behaviors RI #20 had. CNA #12 said, she never knew RI #20 to have behaviors. CNA #12 said she saw RI #20 wandering/walking in the hall a few times. A statement dated 04/04/2025 signed by CNA #42 revealed that she was at lunch in the break room at about 2:00 AM on 01/13/2025 when RI #20 was found in RI #44's room. CNA #42 said she had seen RI #20 wander at times. During an interview on 04/08/2025 at 3:30 PM, LPN #26 reported that RI #20 wandered in the hallway and was easily redirected. An interview with LPN #17 was conducted on 04/07/2025 at 4:44 PM. LPN #17 reported that RI #20 tended to wander into other residents' rooms but would exit if requested. LPN #17 said that RI #20 occasionally masturbated in his/her own room, but to her knowledge, this occurred in no other locations. On 04/08/2025 at 9:15 AM an interview was conducted with CNA #16 who said that RI #20 wandered up and down the hallway but could be easily redirected. CNA #16 stated that she had observed RI #20 engaging in masturbation within his/her room. When asked how the staff managed RI #20's sexual behavior, she explained that if the door was open, they would close it and pull the privacy curtain if a roommate was present. During an interview with the Director of Nursing (DON) on 04/03/2024 at 4:45 PM, the DON was asked if RI #20 ever masturbated in front of other people. The DON said, no, she knew he/she had in his/her room. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A follow-up interview was conducted on 04/10/2025 at 6:13 PM with the DON. During the interview, the DON was questioned about the measures staff were taking to prevent RI #20 from entering the rooms of other residents at the time of the incident on 01/13/2025. The DON indicated that staff would have made observations to ensure RI #20 did not wander into other residents' rooms. However, when asked about the actions of the staff on 01/13/2025 when RI #20 was discovered in RI #44's room, she said she was unaware of the actions. When asked whether staff should have been monitoring RI #20 on 01/13/2025, she said that they should have been attentive to the hallway. Regarding the care plan for RI #20 that was in effect on 01/13/2025, concerning behavioral issues, she referenced the care plan, which stated that RI #20 required redirection. When asked if any of the listed interventions could have prevented RI #20 from entering RI #44's room, she cited the guideline: When acute behaviors are noted, intervene promptly to reduce the risk of escalation, which may be more challenging to manage or redirect. On 04/11/2025 at 12:57 PM another follow-up interview was conducted with the DON regarding the Behavioral Health note dated 01/14/2025. The DON was asked which family reported that RI #20 was masturbating in front of others. The DON said the sister had reported to her during a meeting with the ADM and herself after the incident and she reported that he/she had masturbated in the shower but never in public places. The DON said that would be a problem. The DON said she was not sure when the meeting was held or if it was documented. The DON said the facility addressed the behavior in RI #20's behavior care plan, but it did not address specifically masturbation but did say inappropriate behaviors. On 04/03/2025 at 3:30 PM an interview was conducted with the ADM who said RI #20 did wander and had entered into other residents' room. The ADM said when RI #20 wandered staff redirected him/her. The ADM said RI #20 had no sexual behaviors in the past. On 04/09/2025 at 12:21 PM an interview was conducted with the ADM. During the interview, the ADM was asked about the management of RI #20's behavior on the morning of 01/13/2025, when RI #20 entered the room of RI #44. The ADM said he did not know why staff did not see RI #20 entering RI #44's room. When asked what could have prevented this incident, he stated that if staff had noticed RI #20, they could have redirected him/her away from the room. He said that one staff member was on break during the incident, and another might have been attending to other residents, although he could not confirm that. The ADM concluded by stating the negative consequence of RI #20 entering RI #44's room was RI #20 was discovered sitting on RI #44's bed without clothing from the waist down, touching RI #44's leg. On 04/04/2025 at 9:12 AM an interview was conducted with RI #44's Responsible Party (RP). The RP reported that on 12/10/2024 she was visiting and saw RI #20 masturbating while looking into RI #44's room. The RP said she told an unknown staff, and they apologized and closed RI #20's door. The RP said prior to that incident RI #44's roommate was RI #33. The RP reported that RI #33 would disrobe, and RI #20 would go into the room and look at RI #33. A review of RI #33's medical record indicated he/she was moved to the [NAME] Wing on 10/10/2024. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/04/2025 at 12:44 PM an interview was conducted with the Medical Director (MD), and she was asked about the incident of sexual abuse of RI #44 by RI #20. The MD said, she was aware of the incident of 01/13/2025 but was not aware RI #20 had any other sexual behaviors. The MD continued to say, another resident would at times take their clothes off and RI #20 would look in at the other resident who was undressing. The MD said, because RI #20 would watch the other resident undress, the other resident had been moved to another room. ********** On 04/15/2025, the facility submitted an acceptable removal plan, which documented: 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: a. The facility failed to ensure staff managed and addressed RI #20's behaviors including masturbation and wandering. Specifically, on 01/13/2025 at approximately 2:00 AM, LPN #13 witnessed RI #20 sitting on RI #44's bed, without clothing from the waist down, and making contact with RI #44's leg, caressing RI #44's hip and thigh. Facility staff had knowledge of resident masturbating, family members witnessed resident masturbating, a Behavioral Health note dated 1/14/2025 documented family had reported resident would masturbate in front of others. The facility failed to care plan these behaviors with interventions to protect other residents. b. LPN #13 removed Resident #20 from Resident #44's room on 1/13/25 at approximately 2 am and initiated 1:1 supervision for Resident #20 to ensure safety and prevent further incidents. c. RI #20 was relocated to room on the other end of the center. d. Behavioral Health was contacted and assessed resident on 1/14/25 - Recommendation was to discontinue 1:1 sitter and initiate Q 15-minute checks while medications have time to become efficacious. Q 15 min checks were initiated by the DON in alignment with nationally recognized nursing practice standards, close monitoring is defined as visual checks every 15 minutes. This frequency is commonly accepted in clinical practice for residents identified as high-risk, including during behavioral concerns, elopement risk, or post-incident observation. The assigned staff were to complete the documentation flow sheet. Charge nurses verified staff were monitoring and observing resident every 15 minutes, and staff submitted the flow sheet to the DON for review when completed. Recommendations from Behavioral Health (BH) are reviewed by the Director of Nursing (DON) or designee. The DON/designee followed the recommendations of the psych provider. The resident continues on Q 15-minute checks and has had no behaviors since 1/13/2025. e. RI #20 non-pharmacological intervention in place on 1/13/25 include explaining care prior to, engage in memory stimulating conversations, intervene and observe for pain, provide reorientation and redirection, offer simple choices, involve family, assess for unmet needs like hunger, thirst, toileting, and environmental stressors. f. RI #20 was started on Cimetidine 300 mg on 1/16/25, to reduce sexual desire by its anti-androgen effects. 2. Identification of other residents having the potential to be affected: (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. Other residents with wandering and sexual behaviors in the center have the potential to be affected. b. All residents in the center were assessed using the Wandering Behavior Clinical form, by the Care Manger/designee on 04-12-2025 for wandering, going into others' rooms, pacing, exit seeking, shadowing, aimless walking, along with triggers and interventions. Regional Nurse consultant reviewed assessments for triggers and intervention to individualize their care plans. 8 found to have wandering tendencies, 6 had a known history of going into others' rooms. Noted of the 6 residents who enter others' rooms, their BIMs scores are low, indicating at least intermittent confusion, and they are redirectable. c. No other residents were reported to have sexually inappropriate behavior including masturbation. The regional Nurse consultant reviewed resident progress notes from 1/1/2025-current reviewing for sexually inappropriate behaviors none noted. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences include: a. On 4/12/25 [NAME] President of Risk Management provided in-service for the Administrator and Director of Nursing training on the facility's Behavioral Health Services Policy and facility's Elopement and Wandering Resident Policy to include management of wandering behaviors and entering other rooms and for behaviors that that increase residents risk of abuse like masturbation, wandering, cursing, shadowing, touching, calling out, and disrobing. b. Facility-wide staff training began on 04/11/2025, by the Director of Nursing/ designee. No staff are permitted to work until this training is completed. The training covered: i. The abuse policy. This policy emphasizes that all residents have the right to be free from sexual abuse, outlines how to identify abuse, and mandates immediate residents when abuse is suspected or observed, by physically moving the resident and the aggressor away from each other. When abuse is suspected or observed report to abuse coordinator once residents have been provided safety. An incident report is completed, and reports are reviewed by the DON and Administrator. ii. When any staff observe behaviors, staff should report behaviors to charge nurse for documentation in the medical record. Behaviors are reported during shift-to-shift report by charge nurses. IDT team reviews documentation in clinical meeting for interventions/follow up. iii. Residents identified at risk for wandering into others' rooms will be reviewed during monthly risk meetings, by the interdisciplinary team. Residents at risk for wandering into resident's rooms will have, individualized, person-centered care plans will be developed by the MDS coordinator/designee, implemented by all staff providing care to the resident, the charge nurse will monitor to ensure care planned interventions are implemented and effective each shift, the charge nurses will communicate with the IDT team if care planned interventions are ineffective, and the MDS coordinator will revise CP as necessary. This is not a new process the MDS coordinator already performs this process. DON/designee will monitor the schedule for staff who have not completed the training. DON/designee will provide training prior to the start of the shift. Staff not physically present were in-serviced via phone. No staff are permitted to work until this training is completed. 93 staff have been in-serviced, with 2 remaining to be trained. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Care plans were reviewed by Regional Director of Clinical Reimbursement on 4/14/25 to ensure they were appropriate, and person centered and that they considered safety of the residents. d. QAPI Committee meeting was held 04-14-2025 to review allegations involving behaviors of wandering and sexual inappropriate behaviors including masturbation to include incidents originating 5/27/24 - current Investigations. The Interdisciplinary Team (IDT) identified eight residents requiring care plan reviews that were completed related to wandering and sexually inappropriate behaviors. The Quality Assurance and Performance Improvement (QAPI) team initiated a review to identify trends in wandering and sexual behaviors, assess potential behavioral triggers, and ensure that appropriate, individualized interventions were implemented and documented in the care plans. e. The regional nurse consultant in-serviced the DON 4/14/25 regarding the process to follow with psych provider recommendations. Upon receipt of the recommendation the DON/designee reviews the recommendations contacts the physician prior to implementation. If the physician does not approve, they will provide rational and document, it in the progress notes or the DON/designee will document it in the progress notes. If approved the charge nurse will write an order in the resident's record. Facility requests IJ removal plan to be effective on 04-15-2025. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/14/2025. 2.) Cross reference F600. On 06/13/2024 the State Agency (SA) received an initial Facility Report Incident (FRI) alleging RI #20 was physically abused by RI #31 who approached RI #20 from behind, swatted RI #20 several times, hit RI #20 in the upper back and back of the head. The report included that RI #31 had demonstrated worsening agitation during the week and was being monitored. RI #20 was admitted to the facility on [DATE] and had diagnoses to include Epilepsy. RI #20's quarterly MDS assessment with an ARD of 06/07/2024 documented a BIMS score of three of 15 which indicated severe cognitive impairment. RI #31 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Alzheimer's Disease. RI #31's quarterly MDS with an ARD of 05/28/2024 documented a BIMS score of three of 15 which indicated severe cognitive impairment. RI #31's care plan for a history of behaviors with a start date of 01/30/2024 described behaviors of being combative with caregivers and at risk for altercations. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #31's progress notes were reviewed, and an entry dated 06/13/2024 at 1:59 PM documented: . (RI #31) HAS BEEN VERY AGITATED THIS SHIFT, (HE/SHE) HAS ATTEMPTED TO HAVE PHYSICAL ALTERCATIONS WITH TWO OTHER RESIDENTS, RESIDENT (referred) TO ONE RESIDENT AS THE BITCH WITH THE PIGTAIL AND TRIED TO SLAP (HIM/HER). (RI #31) WAS GIVEN PRN (as needed) ATIVAN, WHICH (WAS) INEFFECTIVE. (RI #31) BECAME AGITATED WITH ANOTHER RESIDENT BECAUSE (HE/SHE) THOUGHT (HE/SHE) WAS (HIS/HER) (child) AND HAD SPENT A LOT OF MONEY . (RI #31) JERKED A TOWEL OFF (HIS/HER) LAP AND (attempted) TO HIT (HIM/HER) WITH IT, NURSE REDIRECTED AND (asked) THE OTHER ONE TO GO DOWN THE HALL FOR A MOMENT AND (HE/SHE) FOLLOWED (HIM/HER) DOWN THE HALLWAY AND HIT (HIM/HER) ON THE BACK OF THE HEAD 3 TIMES. (HE/SHE) STATED (HE/SHE) IS A COMPLETE LIAR. NURSE REDIRECTED RESIDENT AND WALKED (HIM/HER) TO AN OFFICE WHERE (HE/SHE) CALMED DOWN . On 04/08/2025 at 10:26 AM an interview was conducted with Licensed Practical Nurse (LPN) #17 who was the nurse at the time of the incident on 06/13/2024. LPN #17 said, they were in the television room and RI #31 was agitated. LPN #17 said RI #31 thought RI #20 was his/her child, whom RI #31 thought (He/she) stole everything we had. LPN #17 said, she instructed RI #20 to go to his/her room. LPN #17 said as RI #20 began to go down the hall, RI #31 got up, walked quickly to behind RI #20, and hit RI #20 in the back of the head three times before they were separated. LPN #17 said, RI #31's increased behaviors and agitation that week could have been due to Dementia and some days RI #31's agitation was worse. On 04/08/2025 at 9:19 AM an interview was conducted with CNA #16 who witnessed the incident on 06/13/2024 between RI #20 and RI #31. CNA #16 said, RI #31 walked down the hallway toward RI #20, whom RI #31 thought was his/her child who had stolen money from him/her. RI #31 hit RI #20 in the back of the head three or four times with an open hand. CNA #16 said, she intervened to separate the residents. CNA #16 said, RI #31 would become agitated and combative with staff during care due to Dementia. On 04/10/2025 at 9:33 AM CNA #16 was asked follow-up questions. CNA #16 said, the abuse could have been prevented if they had moved RI #31 to the other hall. When asked about supervision level, CNA #16 said, they would check on RI #31 every two hours and monitor RI #31 when out of the room in the day area. RI #31's care plans did not include interventions, or the level of supervision RI #31 required to prevent other residents from being abused by RI #31's verbal and physical behaviors. 3.) On 08/14/2024 at 8:51 PM the State Agency received a Facility Reported Incident (FRI) alleging physical abuse when RI #325 was discovered in RI #59's room agitated and being aggressive, a family member tried to get him/her out, a nurse heard the incident, upon assessment there were no injuries noted, RI #325 was sent out for behavioral and threat issues. RI #325 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Acute Cystitis without Hematuria, Delirium due to known Physiological Condition, and Dementia with Behavioral Disturbance. A review of RI #325's annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 07/19/2024 revealed RI #325's ability to make daily decisions was severely impaired. (continued on next page)

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F 0740 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	RI #59 was admitted to the facility on [DATE] with diagnoses to include Dementia without Behavior and Schizoaffective Disorder. A review of RI #59's admission MDS with an ARD date of 07/10/2024 revealed RI #59's BIMS was 12 of 15 which indicated RI #59 had moderate cognitive impairment. The facility investigative file contained a handwritten statement dated 08/14/2024, signed by CNA #35 which documented: . I was in the Room . helping (with another resident) when I heard Screaming down the hall . I walked out with the other CNA and seen a visitor standing outside (another room) we went to check I seen (RI #325) yelling at (RI #59) and (RI #325) holding (RI #59's) babydoll (RI #59) then told me that (RI #325) had slapped (RI #59) and taken (his/her) babydoll. (RI #325) started cussing us out and yelling at other residents and going into other resident's rooms cussing at them. RI #325's medical record included Nurses Notes documenting a history of aggressive and combative behavior toward staff. Specifically, on 07/28/2024 an entry documented: . RESIDENT AGGRESSIVE TOWARDS STAFF, CURSING SLAPPING AND SPITTING, CHURCH LADY TRIED TALKING WITH (HIM/HER) DID NOT WORK . RESIDENT YELLING . HAD TO BACK AWAY FROM RESIDENT TRIED TO HIT ME . The facility investigative file contained a typed statement titled Office of Administrator dated 08/21/2024 which documented: . (RI #325) was demonstrating behavior issues prior to the incident . It appears (RI #325) was confused and confronted (RI #59) in (his/her) room across the hall and took (RI #59's) baby doll. (RI #59) claims that (he/she) was slapped in the forehead by (RI #325) . (RI #325) was removed from the room . (his/her) behavior was uncontrollable, . An emergency IDT (Interdisciplinary Team) meeting was done, and a Root Cause Analysis was done as well as a 4 Point Plan of Correction. On 04/10/2025 at 4:22 PM an interview was conducted with the ADM. When asked if RI #325 had any behaviors, the ADM said, RI #325 would wander but he did not recall any physical aggression. RI #59's care plans did not include interventions, or the level of supervision RI #59 required to prevent other residents from being affected by RI #'s 59's aggressive behaviors.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and review of facility policies titled,OnTray Dietary Policies and Procedures, Use-By Guideline Handout, Ice Machine: Bin Type and Scoop, Hood, Vents & Filter the facility failed to ensure: 1) food items in the freezer were labeled; 2) the ice machine was cleaned and; 3) the stove hood bulbs and stove hood was free of a a grease like substance. This had the potential to affect 63 of 63 residents who received meals from the kitchen. Findings including: A review of a facility's policy titled, Use-By Guidelines Handout with no date revealed: The following guide can be used to determine a use-by date when labeling opened or unopened food that must be used within a certain time frame. Foods with a manufacturer's use-by date should still require an opened-on date once the item is opened. On 04/02/2025 at 8:33 AM, the surveyor and the Dietary Director (DD) #27 toured the kitchen. The surveyor and the DD observed diced potatoes frozen in a large bag, six hamburger patties in a large bag, chicken thighs in a large bag, about sixty potatoes tarts in a large bag, all without an opened or use by date on the bags. On 04/04/2025 at 9:33 AM, an interview was conducted with the DD. She was asked what items in the freezer were not labeled. She stated forty rolls, five hamburger patties, and a five-pound bag of chicken. The DD was asked why were the items not labeled and she stated she did not have an answer for that. The DD was asked who was responsible for labeling and she stated the cooks. The DD continued, when staff put stuff back, they should be labeling items. The DD was asked why should items be labeled and she stated, first in first out to make sure they know what it was and to use it by the use by date. The DD said, staff was last trained on labeling food items in January. The DD said, it was important to liable with dates to make sure they were utilizing the old first. The DD said, the potential harm to the residents when food items were not labeled was making residents sick and they wanted to ensure sanitation was followed to prevent food borne illness. On 04/04/2025 at 9:47 AM, an interview was conducted with Register Dietitian (RD) #28, The RD was asked why should food items be labeled. The RD stated, to make sure they were using the food items by the use by date, to make sure nothing was expired, and the residents have a good quality of food. 2) A review of a facility's policy titled, Ice Machine: Bin Type and Scoop with no date revealed: Policy: The ice machine should be deep-cleaned . Purpose: To ensure food safety and sanitation . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/02/2025 at 8:33 AM, the surveyor and the DD observed a black substance in the upper corner of the ice machine next to the ice guard on the inside. On 04/04/2025 at 9:34, an interview was conducted with the DD and she was asked what did she see in the ice machine. The DD stated wear and tear on the outside left and on the inside a little dirt. The DD was asked why was the dirt there and she stated that staff needed to do their weekly cleaning. The DD was asked who was responsible for cleaning the ice machine and she stated everyone was responsible. She also stated that maintenance was supposed to clean it quarterly. The DD was asked why was it important that the ice machine was cleaned. The DD stated because ice was a food, and we needed to treat it like a food. The DD was asked when wiping in the upper corner of the ice machine what came off on the paper towel. The DD stated dirt. On 04/04/2025 at 9:47 AM, an interview was conducted with the RD and she was asked why was it important that the ice machine was clean. The RD stated, the ice machine needed to be clean so it would not grow any organism in the ice machine and not make the residents sick. 3) A review of a policy titled, Hood, Vents & Filters with no date revealed: . Purpose: To ensure food safety. On 04/04/2025 at 8:33 AM, an observation was made of the bulbs under the stove hood and they were dirty and the stove hood was dirty with a grease like substance dripping on the left and right side of the hood. On 04/04/2025 at 9:40 AM, an interview was conducted with the DD and she was asked what did she see on the stove hood right side and left side. The DD stated a little bit of grease dripping. She was asked why was it there and she stated, monthly cleaning was not done. She was asked who was responsible for cleaning the stove hood and she stated, the nighttime dish washer. The DD was asked to describe what she saw under the hood on the right and left side of the hood. The DD stated dripping grease. The DD was asked what did she see on the bulb covers and she said grease. The DD was asked why was it important that the hood and bulbs be free of grease. The DD stated to prevents fires. The DD was asked to describe the grease. The DD stated that when the water hit it, it looked like it was dripping down.

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Arabella Health & Wellness of Grand Bay	13750 Highway 90 West Grand Bay, AL 36541

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews and review of a facility policy titled OnTray Dietary Policies and Procedure, the facility failed to ensure the dumpster doors were closed on dumpsters one and two. This had the potential to affect 65 of 65 residents who reside at the facility. Findings include: A review of an undated facility policy titled, OnTray Dietary Policies and Procedure, revealed: Trash Disposal . Purpose: To prevent the spread of infection and deter pests and rodents. 2. The dietary department should ensure the dumpster lids are closed when disposing of trash . On 04/02/2025 at 9:09 AM, the surveyor toured the dumpster area with the Dietary Director (DD) #27. The dumpster door on one and two dumpsters were opened on the side. The opened dumpster doors were facing each other. On 04/04/2025 at 9:45 AM the DD said, she saw the dumpster and she stated the two dumpster doors facing each other were opened. The DD stated, staff did not close them. The DD stated, all staff in the building were responsible for keeping the dumpster doors closed to keep out rodents, pests, and wildlife and for infection control. She was asked what was the potential harm to the residents when the dumpster doors were open, and she stated it could bring rodents to the facility. On 04/04/2025 at 9:47 AM, an interview was conducted with the Registered Dietitian, and she was asked why should the doors of the dumpers be closed and she stated to keep the pests away.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interviews, record review, review of the Job Description of the Administrator (ADM) and review of the facility's Abuse Policy, the facility's Administrator failed to identify and report sexual abuse in a timely manner to the State Agency. The ADM failed to thoroughly investigate an occurrence of sexual abuse to determine causal factors and develop an action plan for prevention of sexual abuse in the facility. On 01/13/2025 at approximately 2:00 AM, Licensed Practical Nurse (LPN) #13 observed Resident Identifier (RI) #20 sitting on RI #44's bed next to RI #44 who had severely impaired cognition and did not have the capacity to consent to the situation. RI #20 was nude from the waist down and was looking at RI #44 and caressing RI #44's hip and thigh. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or serious psychosocial harm to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.70 Administration. On 04/11/2025 at 5:26 PM, the Administrator (ADM, Director of Nursing (DON), [NAME] President of Risk Management, [NAME] President of Clinical Operations, and Senior Regional director of Clinical Operations were provided a copy of the IJ template and notified of the finding of immediate jeopardy in the area Administration at F835-Administration. The IJ began on 01/13/2025 and continued until 04/14/2025 when the survey team verified onsite that corrective actions had been implemented. On 04/15/2025 the immediate jeopardy was removed, F835 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. These failures of the Administrator had the potential to affect all residents residing in the facility. This deficiency was cited as the result of the investigation of complaint/report number AL00049904. Findings Include: Review of the Administrator's Job Description documented the following: . Position Purpose Leads, guides and directs the operation of the healthcare facility in accordance with local, state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents . Required Qualifications . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Knowledgeable of skilled nursing home regulations, procedures, laws, regulations and guidelines pertaining to long-term care . Major Duties and Responsibilities Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as it programs and activities, in accordance with current state and federal laws and regulations . Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. Establishes an ongoing system to monitor these key indicators such as the Quality Assurance and Performance improvement process throughout the facility . Knows and understands . procedures . Code of Federal Regulations, Appendix PP State Operation Manual . and all other regulatory entitles that may apply . Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse, neglect, mistreatment, misappropriation etc. are reported to the correct entity within the stated regulatory requires . Additional Tasks . Promotes and protects all residents' rights Establishes a culture of compliance by adhering to all facility policies and procures . Reports any allegation of abuse, neglect, misappropriation of property, exploitation, or mistreatment of residents to appropriate regulatory entities. protects residents from abuse and cooperates with all investigations . Personal Skills and Traits Desired . Makes independent decisions when circumstance warrant such action . (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/11/2025 at 10:41 AM an interview was conducted with the ADM. The ADM was asked what was the system in place to investigate allegations of abuse and injury of unknown origin. He said as the Abuse Coordinator, he was responsible for the investigation. The ADM said the investigations should identify all involved persons including witnesses, perpetrator and others that have knowledge of the allegation. Focusing the investigation to determine if abuse, neglect, or mistreatment had occurred and providing completed and through documentation of investigation. The ADM acknowledged that this system for investigating allegations of abuse and injury of unknown origin was in the policy and provided guidance on how to conduct a thorough investigation. The ADM said that a thorough investigation should be conducted using the steps in the policy. The ADM said the facility had not thoroughly investigated all of the incidents that were reviewed and investigated by the survey team. The ADM was asked if all the witnesses' statements were not included in the investigation, how could the facility determine the appropriate corrective action. He said, it would be hard to determine the appropriate corrective action plan if all the witness statements were not collected. When asked why was the abuse policy/process not followed to investigation the alleged allegations. He said, he did not receive any training when he came to the facility as the Administrator. He further said, as the Abuse Coordinator it was his responsibility to report, investigate allegations and follow-up on all investigations to see that changes are put in place to help prevent further occurrences. ********** On 04/15/2025, the facility submitted an acceptable plan, which documented the following: F835 Removal Plan 04/15/2025 1. On 04/11/2025, the [NAME] President of Risk Management conducted an in-service for the Administrator and Director of Nursing addressing all types of abuse and the facility's responsibility to ensure resident safety. The Immediate action(s) taken for the resident(s) found to have been potentially affected include: a. investigate an occurrence of sexual abuse to determine causal factors and develop an action plan for prevention of sexual abuse in the facility. b. The administrator reported to ADPH. c. The ADM failed to identify and report sexual abuse in a timely manner to the State Agency. The ADM was thoroughly trained to include how to identify allegations of sexual abuse by staff observation and repotting, physical signs, and behavioral change, collecting and documenting detailed, thorough statements from all staff involved or present during an incident, including those with knowledge of the response and protective actions taken. It also included guidance on reviewing staff time sheets to ensure all potentially involved personnel are identified and interviewed, with a focus on asking clarifying follow-up questions rather than relying solely on written statements. The State agency is to be contacted for allegations of mistreatment, neglect, abuse, injuries of unknown source, and misappropriation additionally local law enforcement will be notified of all abuse allegations. Additionally, the Abuse Coordinator was trained to conduct a root cause analysis for each incident to identify contributing factors and implement appropriate corrective actions. 2. Identification of other residents having the potential to be affected: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	a. This had the potential to affect all residents. Regional nurse consultant reviewed the complete investigation files of the facility reported incidents using the Investigation checklist form to identify other incidents of sexual abuse reported since 1/1/2025. None were identified. This was completed on 4/12/25. Also reviewed investigations for timely submission to state agency. All were submitted within time frame. 3. Actions taken/systems to be put into place to reduce the risk of future occurrences Include: a. The facility investigation checklist was implemented on 4/12/25 as a guide on conducting abuse / sexual abuse investigations. Administrator (Abuse Coordinator) was in-serviced on 4/12/25 by VP of Risk Management. This checklist will be completed by the abuse coordinator and verified for every reportable incident including sexual abuse investigations. b. On 04/12/2025, a QAPI meeting was completed with the Administrator to ensure understanding of the Administrator's responsibility in implementing and enforcing facility policies. The Administrator will notify Regional Nurse Consultant or the Regional Director of Operations of the incident when the incident happens. They will review and sign off on the Investigation check list prior to submission of the 5-day conclusion. This sign-off will verify that investigations are conducted within the regulatory time frames as well as investigated thoroughly in compliance with the facility's Abuse/Sexual Abuse Policy, QAPI Policy, Behavioral Health Services Policy, and Wandering Policy, and that all required procedures are properly implemented and followed. Facility requests IJ removal plan to be effective on 04-15-2025. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/14/2025.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review, interview and Payroll Based Journal (PBJ) Report, the facility failed to report accurate staff data from Fiscal Year (FY) Quarter 1 (October 1 to December 31) to the Center of Medicare and Medicaid Services (CMS). This affected one quarter of data reviewed during the survey and had the potential to affect all 65 residents in the facility. Findings Include: The PBJ report generated for the quarter October 1-December 21, 2023, documented: . This Staffing Data Report identifies areas of concern that will be triggered . Excessively Low Weekend Staffing . Triggered . Submitted Weekend Staffing data is excessively low . On 04/08/2025 at 4:14 PM a telephone interview was conducted with the Director of Informatic (DI). The DI stated she was responsible for submitting the PBJ to CMS. She sated the previous ownership submitted the PBJ for the first part of the quarter and she submitted part of the PBJ for 11/16/2024 to 12/31/2024. When asked why the facility triggered for excessively low weekend staff, she stated because the facility's time and attendance system clocked salary employees at 7.5 hours per salary workday. The facility should have clocked the salary employees at 8.5 hours because they get 30 minutes for lunch. The DI further stated the facility had a time keeping program system error.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interviews, record review, review of facility policies titled Abuse, Neglect and Exploitation and Quality Assessment and Assurance Committee, the facility's Quality Assurance and Performance Improvement (QAPI) committee, failed to review all allegations of abuse and injuries of unknown origin to ensure thorough investigations were conducted, investigations were conducted per facility policy, residents were protected, and reporting was timely. The Quality Assessment and Assurance (QAA or QAPI) committee did not review incidents of abuse that occurred to ensure the Abuse Policy was fully implemented for all allegations of abuse including staff identifying, stopping (protecting the resident from further abuse), and reporting abuse. The QAA committee did not review the incidents to ensure the allegations were thoroughly investigated to ensure the appropriate corrective actions were taken to prevent further abuse. Specifically, the QAA did not complete thorough review of the following allegations: 01/13/2025 RI #44 was sexually abused by RI #20; 05/27/2024 RI #3 had a fracture due to an injury of unknown origin; 07/15/2024 RI #169 had a fracture due to an injury of unknown origin; It was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was cited in reference to 483.75 Quality Assurance and Performance Improvement. On 04/11/2025 at 5:26 PM, the Administrator (ADM), the Director of Nursing (DON), the [NAME] President of Risk Management, the [NAME] President of Clinical Operations, and the Senior Regional director of Clinical Operations were provided a copy of the IJ template and notified of the finding of immediate jeopardy in the area of Quality Assurance and Performance Improvement at F867-QAPI/QAA Improvement Activities. The IJ began on 01/13/2025 and continued until 04/14/2025 when the survey team verified onsite that corrective actions had been implemented. On 04/15/2025 the immediate jeopardy was removed, F867 was lowered to the lower severity of no actual harm with a potential for more than minimal harm that was not immediate jeopardy, to allow the facility time to monitor and/or revise their corrective actions as necessary to achieve substantial compliance. This deficient practice was cited as a result of the investigation of the Facility Reported Incidents (FRIs), complaint/report numbers AL00047974, AL00049295, and AL00049904. Findings Include: Cross reference F600, F607, F609, F610, and F740. Review of the facility's policy titled, Abuse, Neglect and Exploitation, with an implemented date of 11/16/2024, and a revised date of 11/18/2024, revealed: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Policy: 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 resident property . VIII. Coordination with QAPI A. The facility has written policies and procedures that define how staff communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program. 1. Cases of physical or sexual abuse, for example by facility staff or other residents, will be reviewed for and receive corrective action and tracking by the QAA committee. This coordinated effort results in the QAA Committee determining: a. If a thorough investigation is conducted; b. Whether the resident is protected; c. Whether an analysis was conducted as to why the situation occurred; d. Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); and e. Whether there is further need for systemic actions such as: i. Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/misappropriation/exploitation, ii. Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about, iii. Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions, iv. Measures to verify the implementation corrective actions and timeframes, and v. Tracking patterns of similar occurrences. Review of the facility's policy titled, Quality Assessment and Assurance Committee, with an implemented date of 11/26/2024, and a revised date of 01/14/2025, revealed: Policy: This facility will maintain a Quality Assessment and Assurance (QAA) Committee to identify quality issues and develop appropriate plans of action to correct quality deficiencies through and interdisciplinary approach . (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 01/16/2025 at 01:30 PM, the State Survey Agency received an initial report from the facility regarding an allegation of sexual abuse between RI #20 and RI #44 that occurred on 01/13/2025 at approximately 2:00 AM. According to this initial report, the accusation of sexual assault was reported to the administrator via resignation letter. The QAPI documents provided by the facility outlined a four-point plan and included a five-day summary concerning the incident involving RI #20 and RI #44. Neither of the documents indicated that the QAPI committee had recognized that the allegation of abuse was not reported in accordance with Center for Medicare & Medicaid Services (CMS) guidelines or that the facility failed to conduct a thorough investigation including ensuring the investigation focused on whether abuse had occurred, the extent, cause. Additionally, the QAPI failed to identify that the facility failed to determine when the residents were separated and how RI #44 was monitored immediately following the incident, failed to obtain thorough statements from staff who were working at the time, and failed to ensure video recordings from the night of the incident were preserved and/or that a summary of the footage was documented. An interview with the Medical Director (MD) was conducted on 04/11/2025 at 10:44 AM. The MD was asked about the incident involving RI #20 and RI #44. The MD stated she recalled that a QAPI meeting was held on 01/13/2025 which she did not attend but was informed about by the staff. When asked what was discussed she stated that RI #20 was placed on one-on-one monitoring after the incident. An interview with the Director of Nursing (DON) was conducted on 04/11/2025 at 12:15 PM. During the interview, the DON was asked about her responsibilities on the QAPI committee. She indicated that she had undergone QAPI training prior to her employment in January of 2025. The DON said that her responsibilities on the QAPI committee involved identifying issues, formulating solutions, and engaging in discussions with the team. When questioned about her involvement concerning abuse allegations, she said her duty was to ensure the implementation of the four-point plan and to determine if any modifications or updates were necessary. The DON noted that in January, the team met following an incident that involved RI #20 and RI #44. The discussions included the one-on-one care for RI #20, a room change for RI #20, and the involvement of Behavioral Health (BH) with both RI #20 and RI #44. Upon being asked to outline the processes, decision-making, and investigative analysis, she explained that any allegations of abuse would be addressed, detailing the nature of the allegations, establishing a corrective action plan, conducting a review to assess its effectiveness, and making adjustments as required. On 05/27/2024 at 5:39 PM the State Agency received a Facility Incident Report (FRI) alleging an Injury of Unknown Source involving RI #3 when a CNA notified a charge nurse of bruising to RI #3's middle finger, an x-ray was performed, and results identified a fractured finger. On 05/27/2024 the facility failed to thoroughly investigate an injury of unknown origin to determine the root cause and rule out abuse, for RI #3, a resident who was found to have a bruised and fractured finger. The facility investigative file for RI #3 contained interviews with some staff who worked in the 24 hours before the 05/27/2024 identification of the injury, but none prior to 05/26/2024 that could have had information about the cause or what contributed to the injury of bruising and fracture. Further, the facility file did not contain documentation that a skin or body assessment was completed on RI #3 after the injury was identified. The investigative file contained information about RI #3 and RI #3's Resident Representative giving information about the situation, but no follow-up to their input or investigation of the concerns they voiced. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 04/08/2025 at 3:08 PM an interview was conducted with the Administrator (ADM) who said he was notified on 05/27/2024 at 10:00 AM by FDON #29 of RI #3's bruising of the middle finger. When asked why interviews were not obtained from staff who worked with RI #3 days prior to when injury was identified, the ADM said he only thought to interview direct care staff who worked with RI #3 the day before on 05/26/2024. The ADM said, he did not get interview with some nurses and CNAs who worked on 05/26/2024. The ADM said, he did not speak with or interview other residents to find out anything they might know. When asked about the handwritten note in the investigative file about RI #3 being mishandled and someone being ugly to her, the ADM said, he did not know where the note came from, he was not aware of that information, he did not know where it came from or who wrote it because there was no signature. The ADM said, it was important to the investigation, and he should have been aware of the note. The ADM said, there was not any documentation of discussing the results of the investigation with the family. The ADM said, he did not see evidence of a body audit assessment after the incident or until September 2024. The ADM said, the incident was discussed with the team in the morning meeting the next day. However, there is no evidence the facility identified any of these concerns or developed an action plan to address these concerns going forward. A review of a Facility Incident report (FRI) received on 07/15/2024 at 3:21 PM by the State Agency revealed: . Incident Type . Injury of Unknown Source . Incident Detail . Name (s) of resident (s) involved: (RI #169) . Describe any type of injury to alleged victim (s) such as bruise, scratch, laceration, puncture wound, fracture, bleeding, redness on the skin, etc . Large hematoma located on the right foot with swelling . Action (s) taken by the facility in response to the incident. Notified family, called for X-ray, and assessed for pain. Full investigation to follow with report . The facility investigative file for RI #169 was reviewed and revealed no evidence of staff or resident interviews, or any staff who may have had knowledge of occurrences that could have caused or contributed to the injury of bruising and fracture. Also, no evidence that a skin or body assessment was completed after the injury was identified. The facility investigative file contained a typed statement titled Office of Administrator signed by the Administrator which documented: . Based on the investigation it appears . (RI #169's) injury happened without any known cause. I conclude that we have an injury of unknown origin. It does NOT appear that there were any signs of abuse nor neglect that caused the injury. We had a QA meeting with the interdisciplinary team to discuss this issue and how to prevent future occurrences. On 04/10/2025 at 11:27 AM the ADM was asked about the incident and the investigation for RI #169. The ADM said, after review of the investigative file it did not appear to be a thorough investigation. The ADM said, it was taken to QAPI for review. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The four point plan in the investigative file was not dated, indicated attendance only by the ADM, Medical Director, and Social Services, and did not include identification of a lack of evidence of a thorough investigation or action plan for thorough investigations in the future. ********** On 04/15/2025, the facility submitted to acceptable plan, which documented the following: F867 Removal Plan 04/15/2025. 1. Immediate action(s) taken for the resident(s) found to have been potentially affected include: a. The facility QAPI Committee failed to review all allegations of abuse and Injury of Unknown Origin to determine thorough investigations were conducted, residents were protected, and reporting was timely. Examples of abuse allegations and injury of unknown origin not thoroughly investigated include: 5/27/2024 RI #3 had a fracture due to injury of unknown origin. 7/15/2024 RI#169 had a fracture due to injury of unknown origin. 8/14/2024 RI #325 and RI #59 had an physical altercation. 10/24/2024 RI #19 was verbally abused by a CNA. 1/13/2025 RI #44 was sexually abused by RI #20. The QAPI Committee further failed to ensure all contributing factors were identified to ensure appropriate corrective actions were implemented after an LPN wrote a nursing note documenting that she responded to a call light and observed RI #20, a resident with known sexual and wandering behavior, entered RI #20 room and was observed nude from waist down, sitting on RI #44's bed rubbing and caressing his/her hips and thighs. The LPNs note indicated she ran to get help. Further, the LPNs observation occurred while several staff were on their lunch break. The QAPI Committee further failed to ensure an accurate determination was made regarding whether sexual abuse occurred during the facility's investigation. b. On 04/11/2025, the [NAME] President of Risk Management conducted an in-service for the Administrator and Director of Nursing addressing all types of abuse and the facility's responsibility to ensure resident safety. The training emphasized the importance of collecting and documenting detailed, thorough statements from all staff involved or present during an incident, including those with knowledge of the response and protective actions taken. It also included guidance on reviewing staff time sheets to ensure all potentially involved personnel are identified and interviewed, with a focus on asking clarifying follow-up questions rather than relying solely on written statements. Investigative check list was implemented to ensure a thorough investigation is complete. The Tool was reviewed with the DON and Administrator to ensure understanding, regional nurse consultant was on site and completed an investigation with the DON and admin to verify understanding. Additionally, the Abuse Coordinator was trained to conduct a root cause analysis for each incident to identify contributing factors and implement appropriate corrective actions. actions; and to notify Regional Nurse Consultant or the Regional Director of Operations of the incident occurrence. 2. Identification of other residents having the potential to be affected: a. This had the potential to affect any and all residents with injuries of unknown origin, or those with allegations of abuse. All abuse/ injuries of unknown origin reportable files from 05-24-2024 through current date were reviewed by VP of Risk Management and Senior Director of Clinical Operations using the Investigation Checklist form. Reviews completed 04-13-2025. No other instances of abuse or injury of unknown origin have occurred, and no noted late reports submitted to the state agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015406	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arabella Health & Wellness of Grand Bay	13750 Highway 90 West Grand Bay, AL 36541

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	3. Actions taken/systems to be put into place to reduce the risk of future occurrences Include: a. Reportable incident investigation from the prior meeting forward will be brought to the meeting by the administrator for review by the QAPI committee. The investigative check list form will be reviewed and discussed during the committee meeting. Members of the committee are free to voice concerns and make recommendations at any time during the meeting. On 04/12/2025, a QAPI meeting was completed with the Administrator to ensure understanding of the Administrator's responsibility in implementing and enforcing facility policies. The Administrator will notify the Regional Nurse Consultant or the Regional Director of Operations of the incident occurrence. They will review and sign off on the Investigation check list prior to submission of the 5-day conclusion. This sign-off will verify that investigations are conducted in compliance with the facility's Abuse/Sexual Abuse Policy, QAPI Policy, Behavioral Health Services Policy, and Wandering Policy, and that all submission are submitted within the regulatory time frames and required procedures are properly implemented and followed. b. On 4/14/25 a QAPI committee meeting was held with all permanent QAPI members (DON, Administrator, Care Manager, Business development director, business office manager, Activities Director Director of Rehab, dietary manager, Human resources, maintenance and medical records) to train to ensure all QAPI members understand their role and responsibility during the QAPI review of abuse and injury of unknown origin to identify all causal factors and develop action plans based on root cause analysis results. Training also included that all reportable incidents' investigations from the prior meeting forward will be brought to the meeting by the administrator for review by the QAPI committee. The investigative check list form will be reviewed and discussed during the committee meeting. Members of the committee are free to voice concerns and make recommendations at any time during the meeting. Facility requests IJ removal plan to be effective on 04-15-2025. ********** After review of the information provided in the facility's Removal Plan, in-service/education records, as well as staff interviews, and observations, the survey team determined the facility implemented the immediate corrective actions as of 04/14/2025.