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	06/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, residents record review, review of a facility policy titled Abuse, Neglect and Exploitation, review of a Facility Reported Incident (FRI), and review of the facility's investigative file, the facility failed to ensure Resident Identifier (RI) #33 and RI #42 did not physically abuse each other. Specifically, On 04/08/2025 staff failed to provide supervision and intervene when RI #33 was upset and yelling out at RI #42. As RI #42 passed by RI #33, RI #33 hit RI #42, which resulted in RI #42 hitting RI #33 back. According to RI #33's plan of care when RI #33 had acute behaviors staff should intervene promptly to reduce the risk of escalation. This deficiency was cited as the result of the investigation of complaint/report number AL00051008. Findings Include: Review of an undated facility's policy titled, Abuse, Neglect and Exploitation, revealed the following: 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 . Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking . On 04/18/2025 at 9:37 AM the State Agency (SA) received a FRI alleging RI #33 hit RI #42 on the arm while passing by and in return, RI #42 hit RI #33 back. (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

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	06/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RI #42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Dementia, Severe with Agitation, Cerebral Infarction due to Embolism of Unspecified Precerebral Artery and Major Depressive Disorder, recurrent, mild. RI #42's Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 01/22/2025 documented a Brief Interview for mental status (BIMS) score of three out of 15 which indicates severe cognitive impairment. RI #33 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses to include Diffuse Traumatic Brain injury with Loss of Consciousness of Unspecified Duration, Subsequent Encounter, Schizoaffective Disorder, Depressive Type, Major Depressive Disorder, Recurrent Severe without Psychotic Features and Dementia, Unspecified Severity. RI #33's Quarterly MDS assessment with an ARD) of 03/27/2025 documented a BIMS score of one out of 15 which indicates severe cognitive impairment. RI #33's comprehensive care plan was reviewed and revealed a behavior care plan with a start date of 07/31/2024. Specifically, the care plan revealed RI #33 had behavior indicators and was at risk for complications associated with behavior issues. Interventions include . Identifying and analyze key times and location (common area, resident room, etc) circumstances or triggers (i.e.: certain staff, peers, visits .); When acute behaviors are noted, intervene promptly to reduce risk for escalation which may be more difficult to manage/redirect . The facility investigative file contained a handwritten statement dated 04/18/2025, and signed by Certified Nursing Assistant (CNA) #44, a CNA who witnessed the abuse, which documented: Approximately around 6:59 AM I was coming out of a patient's room and [RI #33] started hitting [RI #42] and [he/she] hit [him/her] back. I removed [RI #42] and took [him/her] back to [his/her] room. On 06/11/2025 at 12:53 PM an interview was conducted with CNA #44. The CNA recalled the incident and said when she exited another resident's room, she saw RI #42 smile at RI #33 and RI #33 hit RI #42, and RI #42 hit back. CNA #44 said this occurred in the hallway where Registered Nurse (RN #43) was present. CNA #44 said RN #43 directed her to take RI #42 to his/her room. The facility investigative file contained a handwritten statement dated 04/18/2025, and was signed by RN #3 who witnessed the abuse, which documented: I was on the hall passing morning meds [medications] when the CNA was rolling [RI #42] from [his/her] room. [RI #33] started to yell out curse words towards [him/her] and [she/he] was told by me [RN #43] to stop due to that being inappropriate. [RI #42] began to attempt to wheel [him/herself] back to [his/her] room when [RI #33] reached out and hit [him/her] on [his/her] arm. [He/She] then began to hit [him/her] back on his/her arm. The two were separated and [the administrator] was called immediately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015406	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/2025 at 12:05 PM an interview was conducted with RN #43 regarding the incident on 04/18/2025 between RI #33 and RI #42. RN #43 said she received in report that morning that RI #33 had been agitated. RN #43 said staff assisted RI #33 to the gerichair to sit outside his/her room by the nursing station. RN #43 said she heard RI #33 yell at RI #42 when staff was escorting RI #42 from his/her room to the nursing station to sit. RN #43 said soon afterwards, RI #42 unlocked his/her wheelchair and rolled him/herself back towards his/her room, and in passing, RI #33 sat up, yelled at RI #42, and hit him/her on the arm and RI #33 hit back. On 06/11/2025 at 4:05 PM a follow up interview was conducted with RN #43. When asked to explain RI #33's agitated /behavior episodes, RN #43 said about once a week RI #33 would get agitated where he/she would snatch the privacy curtain or knock things off the bedside table. RN #43 said on the morning of the incident, it was reported that RI #33 was agitated and pulled off the air conditioner cover in the room. RN #43 said staff assisted RI #33 to the gerichair and positioned RI #33 outside the room by the nursing station. RN #43 said while passing out medications, she heard RI #33 cursing RI #42 as CNA #44 was assisted RI #42 by wheelchair to the nursing station. RN #43 said at that time she told RI #33 to stop cursing RI #42. CNA #44 then positioned RI #42 by the wall approximately 5 or 6 feet away from RI #33. RN #43 said approximately five minutes later, RI #42 began to unlock his/her wheelchair and wheel him/herself back towards his/her room. RN #43 said when RI #42 wheeled passed RI #33, he/she reached out and hit RI #42, and RI #42 hit RI #33 back. RN #43 said both residents hit each other several times in the forearm area. RN #43 said the residents were immediately separated by RN #43 and CNA #44. RN #43 said she assessed both residents and noted purplish bruising to RI #42's skin. When asked how the incident could have been prevented, RN #43 said by taking RI #33 back to the room as soon as he/she began cursing RI #42, or not positioning RI #42 in the vicinity of RI #33. When asked how a reasonable person may feel in this situation, RN #43 said threatened and confused. On 06/12/2025 at 9:16 AM the surveyor conducted an interview with the Director of Nursing (DON). The DON said she was made aware of the incident occurring between RI #33 and RI #42 by the Administrator (ADM). The DON said she was told there was a commotion in the hallway and RI #33 hit out or tried to hit out at RI #42 and RI #42 did the same to RI #33. The DON said after the incident room changes were done on both residents. The DON said interventions that were put in place after the incident were RI #33 was put in a private room and RI #42 was moved from the [NAME] Wing to the East Wing, medication reviews were completed, IBH (Integrated Behavioral Health) was consulted, it was added to RI #33's care plan that he/she preferred care provided by a female, Social Service visits were done as needed, and RI #33's care plan was updated to resident has a preference of not being placed by male resident when participating in group activities. When asked what type of abuse it was when RI #33 hit RI #42 and RI #42 hit RI #33 back, the DON said physical. The DON said both RI #33 and RI #42 had impaired cognition. The DON said it would probably upset a reasonable person to be hit for no apparent reason. A review of the facility's five-day summary, dated 04/24/2025, documented the following: . On April 18, 2025, an incident occurred at [NAME] Health and Wellness of Grand Bay involving residents [RI #33] and [RI #42]. As [RI #42] passed by [RI #33] in the hallway near the nurses' station, [RI #33] began yelling obscene language at [him/her]. Before staff could intervene, [he/she] struck [RI #42] on the hand and wrist. In response, [RI #42] struck [him/her] back. A nearby nurse immediately intervened and separated both residents to ensure their safety and prevent further escalation. (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	06/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Both residents were promptly assessed for physical and emotional injuries, and no significant injuries were noted. Following the incident, [RI #33] was moved to a private room to reduce stimulation and promote a calmer environment. [RI #42] was relocated to the opposite side of the building for comfort and safety. The facility administrator, the attending physician, the Ombudsman, Sheriff's office, and both residents' family members were notified in a timely manner. The facility took several immediate actions to address the incident and prevent recurrence. All staff received refresher training on abuse prevention and neglect protocols. Staff were also re-educated on behavior monitoring and de-escalation techniques . A psychiatric consult was requested to help identify possible behavioral triggers and provide guidance for ongoing care. Additionally, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held to review the incident, and a root cause analysis (RCA) was completed. A four-point plan and RCA was implemented as part of the facility's response. The RCA determined that the root cause of [RI #33's] behavior is likely related to [his/her] extensive trauma history . Given [his/her] risk for behavioral outburst, [his/her] care plan now includes trauma-informed behavioral supports and ongoing psychiatric evaluation . On 06/12/2025 at 12:58 PM an interview was conducted with the ADM. The ADM said he was made aware of incident occurring between RI #33 and RI #42 on 04/18/2025 at 7:30 in the morning. The ADM said the facility's investigation revealed when RI #42 passed by RI #33, RI #33 hit RI #42 and RI#42 hit RI #33 back. When asked what type of abuse would hitting be considered, the ADM said physical. The ADM said it would make a reasonable person feel angry and surprised and that is why RI #42 retaliated. The ADM said since the incident there had been no other instances of RI #33 hitting anyone. ********** The facility took the following immediate corrective actions: Step 1: What immediate interventions were initiated for resident identified? 04/18/2025 RI #33 hit RI #42 when RI #42 rolled by RI #33 in his/her wheelchair at the nurse station. Residents were immediately separated to ensure safety. Both residents were assessed for physical and emotional injuries. RI #33 was relocated to private room to prevent further incidents. RI #42 moved to the other side of the building. Administrator, State Agency, Ombudsman and County Sheriff's Office notified Notifications were made to both residents' families and physician. (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	06/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Step 2 What immediate actions were taken to identify all residents potentially affected? What continued and immediate interventions were implemented for identified residents? 04/18/2025 The incident was isolated; no other resident was affected. Other residents that were in vicinity of nurse's station at time of incident were interviewed. Staff present were interviewed and witness statements obtained. RI #42's behavioral care plan updated 04/21/2025 Trauma Informed care plan developed for RI #33. Step 3: What system changes were made or modified? What systematic education was completed to enhance knowledge development of team members? 04/18/2025 Abuse and neglect training completed for all staff. Staff were re-educated on behavior management and monitoring techniques for RI #33. 04/21/2025 Medication reviews completed for RI #33 and RI #42. 04/24/2025 Psych consult requested to assess behavioral triggers and needs. RI #42 seen by Psych 04/29/2025 RI #33 seen by Psych DON or designee will review clinical dashboard on EMR (Electronic Medical Record) system to identify any behaviors 5 days a week and will address as identified. (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	06/13/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Step 4: Continued Quality Assurance audits implemented to ensure enhanced system compliance? Monitoring plan. 04/18/2025 Ad hoc QAPI (Quality Assurance and Performance Improvement) meeting held 04/21/2024 RCA developed 4 point plan of correction developed Clinical dashboard audits will be brought to the center quality committee x 3 months or until substantial compliance is attained and maintained. ********** Upon review and verification of the information provided in the facility's corrective action plan, in-service/education records, the facility's investigation, as well as staff interviews, the survey team determined the facility implemented corrective actions from 04/18/2025 to 04/29/2025, with on-going monitoring implemented; thus, past noncompliance was cited.