

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 015228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER Arabella Health and Wellness of Montgomery		STREET ADDRESS, CITY, STATE, ZIP CODE 4490 Virginia Loop Road Montgomery, AL 36116	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an observation, record review, interviews and review of a facility policy titled, Safeguarding of Resident Identifiable Information, the facility failed to ensure the electronic Medication Administration Record (eMAR) screen was closed, while Licensed Practical Nurse (LPN) #17 was away from the medication cart, and did not reveal medical information pertaining to Resident Identifier (RI) #112. This deficient practice affected RI #112, one of 22 sampled residents, and was observed on 07/23/2025 during the evening Medication Administration observation. This deficiency was cited as a result of the investigation of complaint/report number 2563418. Findings include: Review of an undated facility policy titled, Safeguarding of Resident Identifiable Information, revealed the following: . Policy: It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the safety and confidentiality of the resident's identifiable information . Policy Explanation and Compliance Guidelines: .7. Computer screens showing clinical record information may not be left unattended and readily observable or accessible by other residents or visitors . RI #112 was admitted to the facility on [DATE] with diagnoses to include Type II Diabetes Mellitus, Low back Pain and Pain in Left Arm. A review of RI #112's July 2025 Order Summary Report (Physician Orders) revealed RI #112 had orders to include Finger Stick Blood Sugar (FSBS) twice a day, Fish Oil Oral Capsule 1,000 milligrams give one capsule by mouth three times a day for supplement and Gabapentin Tablet 600 milligrams one tablet by mouth three times a day for neuropathy. On 07/23/2025 at 8:24 PM the surveyor observed a medication cart on the C wing with the eMAR screen open revealing RI #112's name. FSBS, Fish Oil and the medication Gabapentin could also be observed on the eMAR screen. There was no nurse at the medication cart at the time of the observation. On 07/23/2025 at 8:27 PM LPN #17 exited RI #112's room and an interview was conducted. When asked about the the privacy of resident's information on the computer screen when the nurse was not at the medication cart, LPN #17 said, the screen should be closed. LPN #17 said when the screen was not closed it would be a privacy concern. On 07/24/2025 at 12:02 PM, the surveyor conducted an interview with the Director of Nursing (DON). When asked how should the privacy screen on the medication cart be kept when the nurse was not at the cart, the DON said, the privacy screen should be pulled up.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of a Facility Reported Incident (FRI), review of the facility investigative file and a facility policy titled Abuse, Neglect and Exploitation the facility failed to protect Resident Identifier (RI) #8's right to be free from verbal abuse perpetrated by a facility employee, Certified Nursing Assistant (CNA) #21 on 07/10/2025 when Licensed Practical Nurse (LPN) #16 and the Registered Nurse (RN)/Unit Manager #15 witnessed CNA #21 verbally abuse RI #8, a cognitively impaired resident who was already upset, when CNA #21 called RI #8 an ugly [NAME] and said she would say more to RI #8 if she was not on the clock. The Administrator said, for someone to be called an ugly [NAME] would be offensive. This affected one of three residents sampled for abuse. Findings Include: Cross-reference F740. On 07/10/2025 at 3:22 PM the State Agency received a FRI alleging verbal abuse occurred when staff witnessed CNA #21 tell RI #8 he/she was an ugly [NAME] and she would say more if she was not on the clock. A facility policy titled Abuse, Neglect and Exploitation dated 06/11/2025 documented: . 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: . Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. IV. B. Possible indicators of abuse include . 5. Verbal abuse of a resident overheard . RI #8 was admitted to the facility on [DATE] with diagnoses to include History of Traumatic Brain Injury and Mood Disorder. RI #8's Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/13/2025 documented a Brief Interview for Mental Status (BIMS) score of eight which indicted moderate cognitive impairment. RI #8's Behavioral Care Plan initiated on, 04/21/2020, indicated RI #8 had a history of behavioral issues such as verbal abuse, loud talking, being argumentative, and easily agitated. Interventions guided staff to avoiding power struggles with RI #8, intervening when necessary to safeguard the rights and safety of others, and fostering a calm environment and approach towards the resident. The facility investigative file contained a typed, undated Investigative Summary & (and) Conclusion that documented the verbal abuse was unsubstantiated by the facility, even though witnesses heard what CNA #21 said to RI #8, as follows: . According to (Unit Manager #15) unit manager's statement she was walking up to the resident . and stated I will help (him/her) to (his/her) room. (RI#8) responded, I don't want to eat, I am upset, and I want to go home. (Unit Manager #15) ask (RI #8) who had made (him/her) upset and resident pointed back at (CNA #21) he did. that [NAME]. (CNA #21) approached resident and stated to resident (RI #8) you are the [NAME] and not a cute one she then stated, you're lucky I'm clocked in, or I would say what I really want to say. At that time (CNA #21) was removed from the facility . Investigation conclusion: . verbal abuse cannot be substantiated . CNA was terminated on (7/17/2025). The facility investigative file contained a witness statement for RI #8 dated 07/10/2025 that documented: . she said my mom don't love me . I don't like her, I don't want her to be my CNA no more. I'm mad. Who says that to someone? . Another witness statement for RI #8 dated 07/16/2025 documented . I told her she looked like a [NAME] and she told me I was a [NAME], a ugly [NAME]. On 07/23/2025, at 10:30 AM RI #8 was asked about the incident involving CNA #21. RI #8 said, CNA #21 initially upset him/her when CNA #21 said RI #8's mother did not love him/her. RI #8 said, they called each other an ugly [NAME] and CNA #21 was sarcastic. On 07/24/2025 at 4:49 PM Licensed Practical Nurse (LPN) #16 was asked about what she witnessed involving RI #8 and CNA #21. LPN #16 said, the incident occurred during lunch, RI #8 came up to her and complained of a headache, hands shaking and sounding like he/she was going to cry. LPN #16 said, RI #8 reported to her that CNA #21 had said, RI #8's mother did not love RI #8. LPN #16 said, then CNA #21 approached them, RI #8 got upset, did not want to eat, and called CNA #21 a man and CNA #21 responded by calling RI #8 a [NAME]. LPN #16 said, what she witnessed was verbal abuse and CNA #21 was immediately sent home by the charge nurse. On 07/24/2025 at 4:55PM the Registered Nurse (RN) Unit Manager (UM) was asked about the incident involving RI #8 and CNA #21. The UM stated, in the hallway when RI #8 saw CNA #21, RI #8 called CNA #21 him, and then CNA #21 said, RI #8 was a [NAME] and not a cute one and if she was not on the clock she would tell RI #8 how she really felt, then CNA #21 was advised to immediately clock out. The UM said, CNA #21 should have just walked away instead of responding to RI #8. On 07/24/2025 at 11:45 AM the Administrator asked about the verbal abuse involving RI</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, review of Facility Reported Incident (FRI) and the investigative file, the facility failed to ensure an allegation of physical abuse was reported to the Abuse Coordinator on 06/13/2025 when Certified Nursing Assistant (CNA) #12 witnessed Resident Identifier (RI) #94 push RI #110 on the shoulder. The facility failed to report to the State Agency until 06/16/2025. This deficient practice affected RI #110 and RI #94 two of three residents sampled for abuse. Findings include: On 06/16/2025 the State Agency received a FRI alleging physical abuse occurred on 06/13/2025 when RI #94 attempted to choke RI #110; on 06/16/2025 RI #110 reported to the Ombudsman that roommate RI #94 put his/her hands around RI #110's neck and attempted to choke him/her; no injury was noted; RI #110 had changed rooms on Friday 6/13/2025 and the residents had not been in contact. A facility policy titled Abuse, Neglect, and Exploitation, dated 06/11/2025, documented: . VII. Reporting/Response A. 1. Reporting of all alleged violation to the Administrator, state agency, adult protective services, and to all other required agencies . within the specified timeframes: . a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse . RI #94 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Chronic Kidney Disease, Hypertension and Major Depressive Disorder. RI #94's Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/26/2025 documented Brief Interview for Mental Status (BIMS) score of 13 which indicated intact cognition. RI #110 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnoses to include Fracture of First Lumbar Vertebra. RI #110's admission MDS with an ARD of 05/27/2025 documented a BIMS score of 15 which indicated intact cognition. The facility investigative file contained an undated summary of the incident that documented: . On Monday, June 16, 2025, . this writer was visited by Local Ombudsman . She stated that (RI #110) alleged to her that (his/her) roommate, (RI #94) choked (him/her) during a disagreement on Friday, June 13, 2025. An investigation was initiated on Monday June 16, 2025 as soon as we were made aware, . On Friday, 06/13/2025 Residents (RI #110) and (RI #94) were bickering in the resident room. The staff member . (CNA #14) intervened at which time the bickering stopped, and (RI #110) left the room. (RI #110) agreed to another room for a more compatible roommate. (CNA #12) came to the room due to hearing the bickering, she states she observed (RI #94) push at (RI #110). She stated (RI #110) was on the bed and (RI #94) was standing up between the beds. When asked why she did not report her observation she stated because [Assistant Director of Nursing (ADON)] was in the room so I thought she knew. (CNA #12) was asked was (ADON) present when she observed the push and she stated no. (CNA #12) was put on suspension pending outcome for not reporting. (Maintenance Assistant) came in the room . he did not witness any physical interaction/hands on the neck . (Maintenance Assistant) went out of the room with (RI #110) . (CNA #13) came to the room when she heard the bickering. She states, (RI #94) put (his/her) open hand on (RI #110's) shoulder but did not see (him/her) push . (CNA #13) was suspended pending investigation for failing to report her observation. (ADON) came into the room after she heard bickering . did not witness any physical interactions. On Monday, June 16, 2025, local state ombudsman, . came to Administrator office and reported . (RI #110) had told her that (his/her) roommate (RI #94) had choked (him/her). The investigative file contained a handwritten witness statement signed by RI #110 that documented questions and answers to include the following: . What happened with your roommate .? I told (him/her) I was going to smoke and (he/she) told me it wasn't time . (He/she) was upset . My roommate got up reached (his/her) hand through the curtain and started choking me, the nurses knocked on the door and came in the room and saw him choking me. The facility's investigative file contained a hand written witness statement dated 06/16/2025 and signed by CNA #12 which documented: . I saw them arguing, (RI #94) pushed (RI #110's) . (right) shoulder, it wasn't like a hard push, . they were still arguing . we tried to calm them down . On 07/23/2025 at 9:11 AM an interview was conducted with CNA #12 regarding the incident on 06/13/2025 between RI #110 and RI #94. CNA #12 said the morning of 06/13/2025 around 8:00 AM, she and CNA #13 were in the break room when they heard RI #110 and RI #94 across the hall cursing each other. CNA #12 said they quickly got up and went to the room. CNA #12 said RI #94 was cursing, got up, walked over and shoved RI #110 on the shoulder with one hand. CNA #12 described the push as not hard, but soft. CNA #12 said the residents were immediately separated, CNA #12 stayed in the room with RI #94 and did not report it while CNA #13 called for help and RI #110 was escorted from the room in a wheelchair by</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>(continued on next page)</p>

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews and review of a facility policy titled Care and Treatment of Feeding Tubes, the facility failed to ensure feeding tubes were managed in a manner to ensure standard of practice and prevent complications. 1) the facility failed to start Resident Identifier (RI) #109's tube feeding as ordered by the physician at the time RI #109 was admitted to the facility on the morning of 06/26/2024; and 2) the facility failed to position RI #9's head of bed (HOB) elevated at 45 degrees as care planned while RI #9's tube feeding was infusing on 07/23/2025. These deficient practices affected RI #9 and RI #109, two of three residents sampled for tube feeding. This deficiency was cited as a result of the investigation of complaint/report number AL00048535/460742. Findings Include: Review of an undated facility policy titled, Care and Treatment of Feeding Tubes, revealed the following: . Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Policy Explanation and Compliance Guidelines: 1. Feeding tubes will be utilized according to physician orders . 3. The resident's plan of care will address the use of feeding tubes, including strategies to prevent complications . 12. The resident's plan of care will direct staff regarding proper positioning of the resident . 1) RI #109 was admitted to the facility on [DATE]. RI #109's June 2024 Order Summary Report (Physician Orders) revealed RI #109 was to receive Diabetsource by way of a Kangaroo pump at 55 ccs (cubic centimeters) an hour. A review of RI #109's Progress Notes, dated 06/27/2024, documented: . Note Text: Late entry for 6/26/24-resident arrived to facility at 9:15AM . On review of RI #109's June 2024 Medication Administration Record (MAR) there was no evidence RI #109's Diabetsource tube feeding was started at the time RI #109 was admitted to the facility on the morning of 06/26/2024. On 07/24/2025 at 11:30 AM a telephone interview was conducted with Registered Nurse (RN) #26, the nurse assigned to care for RI #109 on the 7 AM -7 PM shift on 06/26/2024. The surveyor shared with RN #26 that RI #109 was admitted to the facility on [DATE] at 9:15 AM and had Physician Orders for Diabetsource to infuse continuously at 55 cc an hour. When asked when was RI #109's tube feeding started, RN #26 said she did not know. RN #26 said the evidence of when a tube feeding was started would be on the MAR, and if a resident had an order for a tube feeding, it should be started as ordered by the physician. On 07/24/2025 at 12:02 PM, the surveyor conducted an interview with the Director of Nursing (DON) and she said she remembered RI #109's family member coming to her about RI #109's continuous tube feeding not being started. The DON said this was sometime in the afternoon the day RI #109 was admitted to the facility, at it was started then. The surveyor asked the DON if a resident was admitted to the facility at 9:15 AM and has an order for a continuous tube feeding, when should the feeding be started. The DON said as soon as the resident comes into the building. When asked where the evidence would be that RI #109's tube feeding was started when he/she came into the facility, the DON said on the MAR. The DON said looking at RI #109's MAR she did not see any evidence RI #109's tube feeding was started the morning RI #109 came into the facility. 2) RI #9 was admitted to facility on 01/15/2025 and readmitted on [DATE], with diagnoses to include Dysphagia and Gastrostomy. RI #9's July 2025 Physicians Orders revealed RI #9 was to receive Isosource 1. 5 by way of continuous feeding pump at 60 ccs an hour. RI #9's tube feeding care plan, with an initiated date of 01/21/2025, revealed RI #9 needed to have the HOB elevated 45 degrees while the tube feeding was infusing. On 07/23/2025 at 11:55 AM RI #9 was observed in bed with the HOB down. On 07/23/2025 at 12:03 PM the surveyor escorted Employee Identifier (EI) #19 to RI #9's room. When asked what position she would describe RI #9's HOB to be in, EI # 19 said the HOB was low. EI #19 said the HOB should be elevated at least 30 degrees. EI #19 said when a resident receiving a tube feeding HOB was not elevated there was a potential for aspiration. On 07/24/2025 at 9:43 AM the surveyor conducted an interview with Certified Nursing Assistant (CNA) #20, the CNA assigned to care for RI #9 on 07/23/2025 on the 7 AM - 7 PM shift. When asked what position should the HOB of a resident receiving tube feeding be, CNA #20 said it should always be up. CNA #20 said there was a potential for the resident to choke when the HOB was flat. CNA #20 said on yesterday (07/23/2025) staff forgot to let RI #9's HOB back up. On 07/24/2025 at 12:02 PM in the continued interview with the DON, the DON said a resident on a continuous tube feeding HOB should be kept at 30 degrees or higher. The DON said there was a potential for aspiration when this was not done.</p>		

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<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident must receive and the facility must provide necessary behavioral health care and services.</p> <p>**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 Services, the facility failed to ensure Certified Nursing Assistant (CNA) #21 responded to resident behaviors in a manner to prevent behavior escalation and in an environment that was conducive to mental and psychosocial well-being, instead of verbally abusing Resident Identifier (RI) #8, a cognitively impaired resident. The facility further failed to ensure CNA #21 implemented interventions that were in place to address RI #8's Behavioral Symptoms to include avoiding power struggles and maintaining a calm environment and approach to the resident. This deficient practice affected RI #8 one of two residents sampled for behaviors. Findings include:</p> <p>Cross-reference F600.</p> <p>On 07/10/2025 at 3:22 PM the State Agency received a FRI alleging verbal abuse occurred when staff witnessed CNA #21 tell RI #8 he/she was an ugly [NAME] and she would say more if she was not on the clock.</p> <p>An undated facility policy titled Behavioral Health Services documented: . Policy Explanation and Compliance Guidelines: . 5. Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial well-being. 11. Facility staff will implement person-centered approaches designed to meet the individual goals and needs of each resident, . m. Focusing the resident on activities that decrease stress . q. Providing support with skills related to verbal de-escalation, coping skills and stress management. RI #8 was admitted to the facility on [DATE] and readmitted on [DATE] and had diagnosis to include History of Traumatic Brain Injury and Mood Disorder. RI #8's Annual Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 05/13/2025 documented a Brief Interview for Mental Status (BIMS) score of eight which indicted moderate cognitive impairment. RI #8's Behavioral Symptoms plan of care with initiation date of 04/21/2020 indicated RI #8 had a history of the following: . exhibits behavioral symptoms including verbal abuse, resisting ADL care, talking loudly, manipulation, argumentative . easily agitated with staff . when they don't do what (he/she) wanted within seconds, . The interventions guiding staff responses included: Avoid power struggles with (RI #8) . Approach/speak in a calm manner . Maintain a calm environment and approach to the resident . Contained within the facility's investigative file was a handwritten witness statement signed by CNA #22 dated 07/11/2025 which documented the following she observed: . I was passing lunch trays . (RI #8) was coming toward the front. CNA #21 came around the corner (and) told (RI #8) your tray is in your room, go eat (and) (RI #8) said you don't tell me what to do, then (CNA #21) said, I'm not trying to tell you what to do, I was just telling you that your tray was in the room so you go eat. (RI #8) kept saying you can't tell me what to do. That's when (RN #15 and LPN #16) came up . (RI #8) said, that [NAME] then (CNA #21) said to (RI #8) (you're) a [NAME] . The statement continued and included questions and answers: . Did you witness (CNA #21) go back to (RI #8) (and) make a statement that (he/she) was lucky she was clocked in or she would tell (him/her) what she really thinks? . yes, I heard her say that .</p> <p>(continued on next page)</p>		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0740</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/24/2025 at 4:58 PM an interview was conducted with CNA #22 and she stated she witnessed the following: CNA #22 was on the unit as lunch trays were being passed, CNA #21 placed RI #8's tray in his/her room and told RI #8 to go eat; RI #8 responded that he/she did not want to eat and said he/she was about to cry and was pissed off; at that time, RN Unit Manager (RN) #15 and Licensed Practical Nurse (LPN) #16 were walking up the hall and RI #8 was crying and told them he/she was pissed off; CNA #22 said she heard RI #8 call CNA #21 that [NAME] . that [NAME] . then CNA #21 said how you gonna call me a [NAME] . you a [NAME].</p> <p>On 07/23/2025, at 10:30 AM RI #8 was asked about the incident involving CNA #21. RI #8 said, CNA #21 initially upset him/her when CNA #21 said RI #8's mother did not love him/her. RI #8 said, they called each other an ugly [NAME] and CNA #21 was sarcastic. On 07/23/2025 at 10:59 AM, an interview was conducted with LPN #16. She stated the following was witnessed: CNAs were on the hall passing lunch trays and CNA #21 told RN #15 she already told RI #8 to come eat, RI #8 told CNA #21 you don't tell me what to do!; RI #8 told LPN #16 that he/she did not want CNA #21 to be their CNA anymore; when asked who, RI #8 pointed at CNA #21 and said him; CNA #21 walked over to RI #8 and asked RI #8, who you calling a him . (RI #8 responded) You are a him you [NAME]!; RI #8 told CNA #21, you're a [NAME], then CNA #21 said umm hum you're one too, and LPN #16 stated this would be considered verbal abuse. On 07/24/2025 at 5:39 PM the Administrator (ADM)/Abuse Coordinator was asked whether RI #8 had a behavior care plan, to which she confirmed that he/she did. Upon being asked about RI #8's behaviors, she described them as being verbally abusive, speaking loudly, and being argumentative. The ADM indicated that the interventions included approaching calmly, maintaining composure, backing off if necessary, intervening when required, and refraining from arguing back. She noted that these interventions were in effect on 07/10/2025, during the incident involving RI #8 and CNA #21. The ADM said the following: she expected that staff would address residents who exhibit verbal abuse by adhering to the care plan, remaining calm, and seeking assistance when necessary; the importance of following the care plan was to prevent escalation. The ADM stated CNA #21 did not react appropriately and the incident could have been avoided had she followed the care plan. This deficiency was cited as a result of the investigation of complaint/report number 2562064.</p>		