

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  015192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/24/2022
NAME OF PROVIDER OR SUPPLIER  Arbor Springs Health and Rehab Center, Ltd		STREET ADDRESS, CITY, STATE, ZIP CODE  1910 Pepperell Pkwy Opelika, AL 36801	
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 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observation, interviews, and review of a facility policy titled, Catheter Care, the facility failed to ensure thorough cleaning of the penis during indwelling urinary catheter care for Resident Identifier (RI) #86, increasing the resident's risk for a urinary tract infection (UTI).</p> <p>The deficient practice affected RI #86, one of two residents sampled with an indwelling urinary catheter.</p> <p>Findings include:</p> <p>Review of a facility policy titled, Catheter Care, dated 06/01/2021, revealed: . Male: .15. Using circular motion, cleanse the meatus with a clean cloth moistened with water and perineal cleaner (soap). 16. With a new moistened cloth, starting at the urinary meatus moving down, cleanse the shaft of the penis .</p> <p>RI #86 was most recently admitted to the facility on [DATE] and had diagnoses to include Retention of Urine and Benign Prostatic Hyperplasia (BPH) with Lower Urinary Tract Symptoms.</p> <p>A review of RI #86's February 2022 Physician Orders, revealed an order dated 06/08/2021 directing staff to provide indwelling catheter care every shift per facility protocol.</p> <p>A review of RI #86's Care Plan revealed a problem onset date of 06/08/2021 regarding a potential for injury related to the presence of an indwelling catheter due to urinary retention. Further review of RI #86's Care Plan also revealed a problem onset date of 06/29/2018 regarding BPH resulting in impaired urinary elimination (retention and overflow incontinence). According to the Care Plan, .BPH increases the risk of urinary tract infections, urinary bladder stones, and obstructive uropathy .</p> <p>A review of RI #86's quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 01/18/2022, identified the resident had intact cognition as evidenced by a Brief Interview for Mental Status score of 13 out of 15. According to the MDS, RI #86 required one-person limited assistance with personal hygiene and had an indwelling catheter.</p> <p>On 02/23/2022 at 3:47 PM, EI #19, Certified Nursing Assistant, provided indwelling urinary catheter care for RI #86. During the observation of catheter care, EI #19 failed to cleanse the shaft of the penis. EI #19 requested to start over and again failed to cleanse the shaft of the penis when the catheter care was provided the second time. Upon exiting the resident's room, during an interview, EI #19 was asked if she cleansed the shaft of the penis. EI #19 said, no, she forgot.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 015192
		If continuation sheet Page 1 of 7

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/24/2022 at 1:40 PM, EI #1, the Administrator, reviewed the Catheter Care policy and stated it should be followed.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, and interviews, the facility failed to ensure:</p> <p>1) Resident Identifier (RI) #223's oxygen was administered in accordance with the physician's order; and</p> <p>2) RI #220's nebulizer mask and tubing was stored in a manner to prevent potential contamination when not in use.</p> <p>This deficient practice affected RI #223 and RI #220, two of four residents sampled for respiratory care.</p> <p>Findings include:</p> <p>1) RI #223 was most recently admitted to the facility on [DATE]. RI #223's diagnoses list included the following: Acute and Chronic Respiratory Failure with Hypoxia (oxygen deficiency), Chronic Obstructive Pulmonary Disease (COPD), and Obstructive Sleep Apnea (OSA, temporary cessation of breathing during sleep).</p> <p>A review of RI #223's admission Minimum Data Set (MDS) dated [DATE] indicated RI #223 had no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 15 out of 15. The resident required extensive assistance of one person for their activities of daily living (ADLs). The MDS indicated diagnoses included COPD and OSA, and the resident received oxygen therapy.</p> <p>A review of RI #223's comprehensive care plans revealed a care plan dated 12/13/2021 related to RI #223's diagnosis of COPD. This care plan included an intervention to administer oxygen therapy as ordered by the physician.</p> <p>A review of RI #223's February 2022 Physician Orders indicated RI #223 had an order for oxygen at two (2) liters per minute (lpm) via nasal cannula (NC) continuous, ordered 02/11/2022.</p> <p>On 02/23/2022 at 3:10 PM, RI #223 was wearing oxygen and the concentrator was set at three liters per minute. The resident, as well as a family member present at the time, both confirmed the resident's oxygen should be set at two liters per minute.</p> <p>On 02/24/2022 at 10:36 AM, RI #223 was sitting in his/her room receiving oxygen at a rate of three liters per minute.</p> <p>During an interview with Employee Identifier (EI) #25, Registered Nurse (RN), on 02/24/2022 at 10:49 AM, EI #25 stated they would look at the physician orders in RI #223's chart to see how many liters of oxygen the resident was supposed to be on. After reviewing RI #223's record, RI #25 stated the resident should be on two liters of oxygen and did not know why the concentrator was set to three liters per minute.</p> <p>During an interview with EI #28, Clinical Care Coordinator, on 02/24/2022 at 11:23 AM, EI #28 stated only the nurse could take care of an oxygen concentrator, and the nurse should refer to the physician's order to know how many liters of oxygen the resident should be on.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with EI #2, Director of Nursing, on 02/24/2022 at 3:40 PM, with EI #1, Administrator, present, she indicated the nurse should look at the physician's orders to know how many liters of oxygen a resident should be on and only the nurses were allowed to adjust the amount of oxygen a resident was receiving.</p> <p>2) RI #220 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).</p> <p>A review of RI #220's February 2022 Physician Orders indicated RI #220 had orders for ipratropium-albuterol (bronchodilators) 0.5-3 milligrams (mg) per three milliliter (ml) give 3 ml (milliliters) via HFN (high flow nebulizer) every four hours as needed for shortness of breath (SOB) or wheezing for 14 days, ordered 02/16/2022.</p> <p>Observation on 02/21/2022 at 10:06 AM and 11:15 AM revealed RI #220's nebulizer mask, canister and tubing were connected to the nebulizer machine and laying on top of the nightstand. According to the MAR, the last time the resident received a nebulizer treatment was on 02/20/2022 at 5:43 AM.</p> <p>Observations on 02/22/2022 at 10:47 AM revealed RI #220's nebulizer mask, canister and tubing were connected to the nebulizer machine. They were dated 02/20/2022. According to the MAR, the last time the resident received a nebulizer treatment was on 02/22/2022 at 6:00 AM.</p> <p>Observation on 02/23/2022 at 8:33 AM revealed RI #220's nebulizer equipment was connected to the machine; the canister had a small amount of fluid in it and the mask was connected to it and had not been rinsed out. According to the MAR, the last time the resident received a nebulizer treatment was on 02/22/2022 at 10:53 PM.</p> <p>During an interview with RI #220 on 02/23/2022 at 8:33 AM, RI #220 stated the staff had only rinsed out his/her nebulizer canister/tubing once since admission to the facility. The resident stated it should be rinsed out every day at least, otherwise it gets sediment built up in it. RI #220 stated the staff lay it on top of the machine when they are done using it. The resident stated he/she had mentioned rinsing it out before, but the staff did not listen.</p> <p>Observations on 02/24/2022 at 8:49 AM revealed the nebulizer equipment was connected to the machine and the canister had a small amount of fluid in it. The mask and the canister had not been rinsed out and stored properly.</p> <p>During an interview with EI #23, Registered Nurse (RN), on 02/24/2022 at 10:59 AM, EI #23 stated the nurses were responsible for cleaning the nebulizer machines daily. EI #23 stated there were no order to clean the nebulizers, but said the canister on the nebulizer should be rinsed out daily and stored in a bag when not in use.</p> <p>During an interview with EI #28, Clinical Care Coordinator, on 02/24/2022 at 11:23 AM, EI #28 stated the nebulizer canister should be rinsed before and after use and should be stored in a bag.</p> <p>During an interview with EI #2, Director of Nursing, on 02/24/2022 at 3:40 PM with EI #1, Administrator, present, she stated the nebulizer canister should be rinsed out daily and stored in a bag.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interviews, and review of the facility's food contract company's policy, Bulk Food - Delivery and Usage, the facility failed to ensure food with an expired use by date was discarded, placing 114 of 117 residents in the facility at risk for foodborne illness if served.</p> <p>Findings include:</p> <p>The facility's contract food service company's undated policy Bulk Food - Delivery and Usage, revealed, .The bulk meals should be held at the proper temperature in the refrigerator and served to residents within 3 days of preparation.</p> <p>During an observation on 02/21/2022 from 9:45 AM to 9:58 AM, the following items prepared in another town by the food service contract company's central kitchen and stored on shelving in the walk-in cooler were observed:</p> <ul style="list-style-type: none"> <li>- Three large aluminum pans (full size steam table pans) containing chicken pot pie and labeled with a prepared date of 02/15/2022 and a use by date of 02/18/2022</li> <li>- One small aluminum pan (1/2 size steam table pan) containing pureed chicken pot pie and labeled with a prepared date of 02/15/2022 and a use by date of 02/18/2022</li> <li>- One small aluminum pan containing corn and labeled with a prepared date of 02/17/2022 with a use by date of 02/20/2022</li> <li>- One small aluminum pan containing pureed green beans and labeled with a prepared date of 02/16/2022 with a use by date of 02/19/2022</li> <li>- Two large pans containing green beans and labeled with a prepared date of 02/16/2022 and a use by date of 02/19/2022</li> <li>- One large pan containing corn and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</li> <li>- One large pan containing chicken fettuccini alfredo and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</li> <li>- One small pan containing pureed baked beans and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</li> <li>- Two large pans containing barbequed pork and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</li> <li>- Two large pans containing baked beans and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</li> <li>- Two large pans containing corn and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- One small pan containing pureed corn and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- One small pan containing pureed barbequed pork and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>During an observation on 02/21/2022 at 10:00 AM, the following food items from the walk-in cooler, noted to be expired per the use by dates, were in the oven:</p> <p>- Two large pans (full size steam table pans) containing barbequed pork and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- Two large pans containing baked beans and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- Two large pans containing corn and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- One small pan (1/2 size steam table pan) containing pureed corn and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- One small pan containing pureed barbequed pork and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- One small pan containing pureed baked beans and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- One small pan containing pureed barbequed pork and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022.</p> <p>During an interview on 02/21/2022 at 10:00 AM, Employee Identifier (EI) #6, Dietary Manager, indicated he was confused why the listed food items were in the oven because the facility usually cooked meals on Mondays, and the food in the oven was not listed on the menu. EI #6 further indicated that catered food was prepared and delivered to the facility by the facility's contracted food service company on Tuesday nights, Thursday nights, and Saturday nights. EI #6 stated the food in the oven should not have been heated up for residents but, instead, should have been discarded.</p> <p>During an observation on 02/21/2022 at 10:46 AM, EI #8 was observed pulling the following expired food items from the oven and discarding them:</p> <p>- Two large pans (full size steam table pans) containing barbequed pork and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- Two large pans containing baked beans and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- Two large pans containing corn and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- One small pan (1/2 size steam table pan) containing pureed corn and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- One small pan containing pureed barbequed pork and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- One small pan containing pureed baked beans and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>- One small pan containing pureed barbequed pork and labeled with a prepared date of 02/17/2022 and a use by date of 02/20/2022</p> <p>During an interview on 02/21/2022 at 10:47 AM, EI #8 indicated she was instructed by EI #6 to discard the food in the oven due to the use by date on the food having passed. EI #8 indicated dietary staff would be preparing lunch as per the menu for the residents.</p> <p>During an interview on 02/24/2022 at 2:45 PM, EI #6 indicated it was his expectation for staff to dispose of food with an expired use by date.</p> <p>During an interview on 02/24/2022 at 4:45 PM, EI #1, Administrator, revealed it was her expectation that dietary served food within its use by date.</p>		