STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015151	A. Building B. Wing	01/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arabella Health & Wellness of Mobile	1758 Springhill Ave Mobile, AL 36607

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18639 Based on record review, interview, and review of facility policies titled Depression - Clinical Protocol, Behavioral Assessment, Intervention, and Monitoring and Antipsychotic Medication Use, the facility failed to ensure Resident Identifier (RI) #51, who received antipsychotic and antidepressant medications, was monitored for behaviors and/or side effects of precribed medications. This affected RI #51, one of four sampled residents receiving an antipsychotic medication and one of two sampled residents receiving an antidepressant medication. Findings include: Review of the facility's Depression - Clinical Protocol policy and procedure, revised in November of 2018, revealed: .Monitoring and Follow-Up .The staff and physician will monitor the resident/patient carefully for side effects of any medications used to treat a mood disorder as well as interactions between antidepressants and other classes of medications . Review of the facility's Behavioral Assessment, Intervention and Monitoring policy and procedure, revised in December of 2016, revealed: .Management .10. When medications are prescribed for behavioral symptoms, documentation will include .h. Monitoring for efficacy and adverse consequences . Monitoring . 4. The nursing staff and the physician will monitor for side effects and complications related to psychoactive medications . 5. If antipsychotic medications are used to treat behavioral symptoms, the IDT [interdisciplinary team] will monitor their indication . a. The IDT will monitor for side effects and complications related to psychoactive medications; for example, lethargy, abnormal involuntary movements, anorexia, or recurrent falling. Review of the facility's Antipsychotic Medication Use policy and procedure, revised in December of 2016, revealed: .Policy Interpreation and Implementation . 16. The staff will observe, document, and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications . RI #51 was admitted to the facility on [DATE]. RI #51's diagnoses included Vascular Dementia With Behavioral Disturbance, Bipolar Disorder, Psychosis, and Major Depressive Disorder. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RI #51's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2021, revealed RI #51 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. The MDS revealed the resident had exhibited no indicators of psychosis and had exhibited no behaviors. Per the MDS, RI #51 required extensive assistance or was dependent upon staff for most Activities of Daily Living (ADLs). The MDS indicated RI #51 had received antipsychotic and antidepressant medication during seven of seven days prior to the ARD and received antipsychotic medication on a routine basis. A review of RI #51's January 2022 Physician Orders, revealed the following orders with an order date of 10/15/2021: olanzapine (Zyprexa; antipsychotic) 2.5 milligrams (mg) in the evening for bipolar disorder and duloxetine hydrochloride (Cymbalta; antidepressant) Delayed Release 30 mg by mouth daily for depression. The Care Plan regarding RI #51's psychotropic medication use, dated 11/22/2021, indicated behavior monitoring per facility protocol and observation for signs and symptoms of drug toxicity, adverse effects, intolerance, or drug interaction would be conducted by staff. The Care Plan regarding RI #51's potential for altered thought processes related to Vascular Dementia With Behavioral Disturbance, Bipolar Disorder, Psychosis, and Major Depressive Disorder, dated 10/14/2021, indicated the resident would be monitored for effects of the medications administered. There was no documentation in RI #51's electronic or paper health record indicating staff monitored RI #51 for target behaviors and/or monitored for side effects of the antipsychotic and antidepressant medications. On 01/06/2022 at 5:19 PM, the Director of Nursing was interviewed. She stated RI #51 had not been monitored for behaviors and/or side effects of the antipsychotic or antidepressant medications since admission. She stated behavior and side effect monitoring should be documented on RI #51's Medication Administration Record (MAR) but no physician orders had been written for such monitoring, which would have resulted in the monitoring being added to the MAR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45714 Based on observations, interviews, and review of facility policies titled Respiratory Program Policy and Procedure and N95 Respirator Mask, the facility failed to ensure staff properly wore source control throughout the facility. Specifically, facility staff were observed wearing N95 respirators (masks) with the mask straps cut and tied to be worn behind the ears instead of around the head; N95 mask straps were observed hanging loosely instead of around the head; and N95 masks were observed not covering the nose and mouth. This had the potential to affect all residents and occurred during the COVID-19 pandemic. Findings include: A review of the facility policy titled, Respiratory Program Policy and Procedure, dated 05/11/2020, revealed, . Training: All required employees will receive training on the following topics .3. Capabilities and limitations of respiratory mask. 4. How to put on and remove the respiratory mask correctly. 5. How to inspect and check the seals of the respiratory mask .8. Users should understand that improper use, maintenance, and storage of respiratory masks may result in exposure that may lead to exposure to airborne disease . A review of the facility policy titled, N95 Respirator Mask, with no date, revealed, .The top strap (on single or double strap respirators) goes over and rests at the top back of your head. The bottom strap is positioned around the neck and below the ears . During an observation and interview on 01/04/2022 at 8:50 AM, the Certified Dietary Manager (CDM) was wearing an N95 mask with the straps cut, tied, and worn around the ears instead of over and around the head. The CDM indicated they were test fitted for the mask and they cut the straps for a better fit around the ears. During an observation and interview on 01/04/2022 at 8:55 AM, the Kitchen Manager was wearing an N95 mask with the straps cut, tied, and worn around the ears instead of over and around the head. The Kitchen Manager indicated they were test fitted for the mask and cut the straps for a more comfortable fit around the ears. During an observation and interview on 01/04/2022 at 8:58 AM, Employee Identifier (EI) #2, a Cook, was wearing an N95 mask with the straps cut, tied, and worn around the ears instead of over and around the head. EI #2 indicated she cut the straps because she could not get it over her head and the mask bruised her face. During an observation and interview on 01/04/2022 at 2:42 PM, the Maintenance Director was observed on the first floor wearing an N95 mask with the loops cut and tied behind their ears. The Maintenance Director indicated he cut and tied the straps around his ears because it was faster to put on and take off since he moved around the building. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 01/05/2022 at 4:16 PM, EI #3, a Licensed Practical Nurse (LPN), was observed wearing an N95 mask with one strap around the back of the head and the other strap hanging below the chin, creating an improper fit and seal. EI #3 indicated she had been trained in N95 use and wore the mask in the way observed because, otherwise, it was too tight, and she could barely breathe. During an observation and interview on 01/06/2022 at 10:59 AM, the Kitchen Manager was wearing an N95 mask with the straps cut, tied, and worn around the ears instead of over the head. During an observation and interview on 01/06/2022 at 11:05 AM, EI #2 was wearing an N95 mask with the straps cut, tied, and worn around the ears instead of over the head. During an observation and interview on 01/06/2022 11:39 AM, EI #4, a Certified Nurse Aide (CNA), was standing in the dining room on the 3rd floor near Resident Identifier (RI) #70, RI #56, and RI #35, who were seated at a dining table. EI #4 wore an N95 mask pulled below the nose and then proceeded to walk into a hallway. EI #4 was also observed walking out of room [ROOM NUMBER], a resident's room, with the N95 mask pulled below the nose and walking into the hall. EI #4 identified she had been trained regarding how to properly wear the N95 mask and knew she was wearing the N95 mask improperly, but stated it hurt her ears bad to wear it properly. During an interview on 01/07/2022 at 8:16 AM, the Administrator indicated the correct way to wear the N95 mask involved putting one strap around the head at the base of the neck and the other strap around the head by the ears. The Administrator stated staff were not allowed to cut and/or tie the straps around the ears or pull the mask below the nose. The Administrator further indicated staff had been trained on how to properly wear N95 masks, noting the potential negative outcome of altering an N95 mask or not having a proper fit was potentially spreading COVID-19. Per the Administrator, four or five staff had tested positive for COVID-19 in the prior 14 days. During an interview on 01/07/2022 at 9:02 AM, the Maintenance Director indicated he was trained on how to wear an N95 mask. The Maintenance Director stated he knew the mask did not seal properly around his face, and the mask was not as effective when the head straps were altered. During an interview on 01/07/2022 at 9:13 AM, the CDM indicated she cut the straps of her N95 mask and was trained on how to properly wear the N95 mask. The CDM was unable to recall when the training was received. During an interview on 01/07/2022 at 9:14 AM, the Kitchen Manager indicated she received training on how to properly wear the N95 mask. During an interview on 01/07/2022 at 9:16 AM, EI #2 indicated she received training on how to properly wear the N95 mask. During an interview on 01/07/2022 at 9:43 AM, the Infection Preventionist (IP) indicated the correct way to wear the N95 mask was to put the straps over and behind the ears and neck and cover the nose and mouth. The IP further indicated staff had been trained on how to wear an N95 mask and that staff were not allowed to cut the straps on the N95 mask or wear the mask hanging down. Per the IP, the potential negative outcome of improperly wearing an N95 mask included the spread of infectious disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 01/07/2022 at 1:36 PM, the IP indicated unit managers and all department heads were to monitor for infection control practices. The unit managers and department heads conducted quality assurance rounds for everything and looked for proper mask use, observed staff entering and exiting rooms, and observed glove use and anything else related to infection control. The IP further indicated that it was the IP who was ultimately responsible for ensuring compliance, noting she was in training but had an Infection Preventionist certificate and completed daily audits when rounds were made. The IP was asked why staff were improperly wearing the N95 masks, and the IP stated, Staff choosing to do just what they want to do. During an interview on 01/07/2022 at 1:49 PM, the Administrator indicated that she and the Director of Nursing (DON) were ultimately responsible for ensuring compliance with infection control practices, but she tried to empower the department heads to enforce rules and relied on the department heads to correct issues because she could not be everywhere. The Administrator further indicated audits were completed during walking rounds and delegated to department heads to ensure compliance so that any issue was reported, up the ladder. The Administrator was asked why she thought staff were improperly wearing the N95 mask and she stated, Lack of concern.