STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105532	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arcadia Health and Rehabilitation Center	10095 Hillview Road Pensacola, FL 32514

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50447 Based on observations, interviews, electronic medical record (EMR), and facility policy review, the facility failed to ensure the interdisciplinary team assessed and determined if a resident was capable of self-administration of medications for 2 of 23 residents sampled for self-administration of mediation. (Residents #118 and #392) The findings include: Resident #392 On 11/18/24 at 11:30 AM, Resident #392 was observed with a tube of Triamcinolone Acetonide (a cream meant to treat skin conditions such as eczema, dermatitis, and allergies) at the bed side. Resident #392 stated he uses this for general itching. He stated the nurses don't know he is using it, and he has been using this medication for [AGE] years. A second observation on 11/19/24 at 9:00 Am revealed the Triamcinolone cream was still at the bed side table. A review of the EMR for Resident #392 revealed diagnoses of Type 2 Diabetes Mellitus with other specified complication, presence of Cardiac Pacemaker, essential Hypertension, Hyperlipidemia, unspecified, benign Prostatic hyperplasia without lower Urinary tract symptoms, unspecified Atrial Fibrillation, Atherosclerotic Heart Disease of native Coronary Artery without Angina Pectoris, Peripheral Vascular Disease, personal history of Peptic Ulcer disease, other Asthma, Muscle weakness, and Chronic Obstructive Pulmonary Disease. A review of medication orders did not show any orders for Triamcinolone or a review by the physician on Resident #392's ability to self-administer his own medications. On 11/19/24 at 3:00 PM an interview with Staff A, a Licensed Practical Nurse (LPN) was performed. She was asked if any residents administered their own medications. Staff A stated that she did not know of any residents who self-administered medications. Staff A was shown Resdient #392's medication in his room. Staff A commented that this medication should not be there, and he does not have an order for it. She told the resident she will ask his doctor for an order. 28603 Resident #118 (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of Resident #118 was conducted on 11/19/24 at 2:36 PM. The resident was in bed and a bottle of Osteo Biflex (a Glucosamine Chondroitin supplement) was observed on his over bed table. An interview was conducted with Resident #118 on 11/20/24 at 10:35 AM. Resident #118 stated he ordered the Osteo Biflex online, administers the medication to himself, and had previously discussed it with his physician. The bottle of medication remained on the over bed table. (Photographic evidence was obtained.) A review of Resident #118's EMR revealed no assessment for the resident to self-administer medications and no care plan for self-administration of medications. An interview was conducted with Employee G, an agency LPN, on 11/20/24 at 10:25 AM. She stated unless the physician approved otherwise, the facility should be administering and storing the Osteo Biflex. She did not know if Resident #118 had been assessed to self-administer medications. An interview was conducted with the Director of Nursing (DON) on 11/20/24 at 10:37 AM. She stated Resident #118 was not assessed to self-administer medications and he should not have the medication at bedside. She expected the staff to observe for medications at bedside and report to the nurse so the facility can screen the resident to determine if they are safe to self-administer medications. A review of the policy on Self Administration of Medication revealed, A resident may not be permitted to administer or retain any medications in his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team. Should the resident's attending physician permit resident to administer his/her medication(s), the following conditions will apply: The Physician's order must be given prior to self-administration Storage of medications in the resident's room must be such that it will prevent access by other residents. Only the medications permitted for self-administration shall be left at the bedside. The Interdisciplinary Care Plan Team must record in the resident's medical record that self-administration has been authorized and shall identify the name, strength, and quantity of each medication retained at the bedside.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28603 Based on observation and staff interview, the facility failed to store resident care equipment in a sanitary manner in 3 of 24 sampled resident rooms. (rooms [ROOM NUMBER]) The findings include: An observation of room [ROOM NUMBER]'s bathroom was conducted on 11/18/24 at 4:02 PM. Three wash basins (2 labeled with 64 A and one not labeled) and an unlabeled bedpan were observed to be sitting on top of the sink. Further observations of room [ROOM NUMBER]'s bathroom was conducted in the presence of Employee F, the Licensed Practical Nurse Unit Manager, on 11/20/24 at 3:00 PM. Employee F observed and confirmed 3 basins stacked on top of each other and one unlabeled bedpan on top of the sink. She stated the items should be stored in the resident's bed side drawer. (Photographic evidence was obtained.) An observation of room [ROOM NUMBER]'s bathroom was conducted on 11/18/24 at 2:50 PM. Three unlabeled wash basins were stacked on top of each other and an unlabeled urinal was sitting on top of the sink. Further observation of room [ROOM NUMBER]'s bathroom was conducted on 11/20/24 at 3:05 PM in the presence of Employee F. Employee F observed the wash basins and urinal, then confirmed the items should be labeled and stored in the resident's drawer. (Photographic evidence was obtained.) An observation of room [ROOM NUMBER]'s bathroom was conducted in the presence of Employee F on 11/20/24 at 3:08 PM. An unlabeled wash basin, unlabeled emesis basin, and unlabeled urinal was observed sitting on top of the sink. Employee F observed the items and confirmed they should be labeled and stored separately. (Photographic evidence was obtained.)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 51235 Based on observations, interviews, and record reviews, the facility failed to implement the plan of care for 2 of 2 residents sampled for falls. (Residents #46 and #3) The findings include: On 11/18/24 at approximately 11:00 AM, Resident #46 was observed sitting on the fall mat beside the bed. Resident #46 was assisted by staff to return to their wheelchair. A review of the most recent care plan for Resident #46, dated 09/16/2024, described Resident #46 as having potential for falls/injury due to impaired safety awareness, being spontaneous, not remembering to use the call light or ask for assistance, and forgetting to use a walker. Part of her plan included using a Dycem mat in her wheechair's seat to prevent slipping out of the wheelchair. On 11/18/2024 at approximately 2:05 PM, and 11/19/2024 at approximately 1:20 PM and 2:50 PM, Resident #46 was observed using her wheelchair. The seat of the wheelchair was visible during observations and a cushion was used in the seat by Resident #46. However, no Dycem mat was observed in the wheelchair either above or under the cushion in the seat. During an observation and interview on 11/20/2024 at approximately 12:45 PM, Staff D, a Certified Nursing Assistant (CNA), was asked about Resident #46's Dycem mat. After checking Resident #46's chair, CNA D confirmed there was not a Dycem mat in the chair. CNA D proceeded to Resident #3's room and revealed that Resident #3 also did not have a Dycem in his wheelchair. CNA D immediately located the Dycem mat in Resident #3's room and placed it in the wheelchair. A review of Resident #3's care plan, dated 9/13/2024, indicated Resident #3 has a potential for falls/injury due to cerumen build-up, poor balance, seizure disorder, and attempts to remain independent. Interventions include Continue Dycem to w/c seat anti-lock brakes checked. On 11/20/2024 at approximately 2:15 PM, an interview was conducted with the Director of Nursing (DON), who, after reviewing resident #46 and #3's care plans, confirmed that both residents should have a Dycem mat in their wheelchairs. The DON stated the minimum data set (MDS) coordinator reviews and updates the quarterly assessments and audits to ensure interventions are completed.