STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105628	A. Building B. Wing	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arabella Health & Wellness of Pensacola	1717 W Avery St Pensacola, FL 32501

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to adequately supervise 27 identified smokers and failed to secure resident's smoking materials, including lighters and cigarettes. This deficient practice placed the resident and others at risk for serious harm and resulted in the facility being placed in Immediate Jeopardy (IJ) when it was discovered that 1 of these 27 residents (Resident #15) had smoking materials in their possession despite orders for using oxygen, had diagnoses of dementia and schizophrenia, and had a roommate who also used oxygen.The findings include:A review of the facility's smoking policy dated January 2026 documented that all smokingˆrelated privileges, restrictions, and concerns must be documented in the resident's care plan and communicated to all personnel involved in the resident's care. The policy further required that any resident with restricted smoking privileges needed to be monitored under the direct supervision of a staff member, family member, visitor, or volunteer at all times while smoking. An observation was conducted of Resident #15 on 04/28/26 at approximately 10:44 AM. Resident #15 was observed sitting up in bed with oxygen in use. Additional observations were conducted of Resident #15 on 4/30/26 at approximately 6:05 PM through 6:30 PM. In these observations, Resident #15 was noted to be sitting in her wheelchair on the smoking patio with a plastic bag containing cigarettes and a lighter in her lap. A joint interview was conducted with Staff B, Certified Nursing Assistant (CNA), and the Facility Activity Director during this observation. They confirmed Resident #15 was identified as an unsafe smoker and required the use of a smoking apron while smoking. Resident #15's Minimum Data Set (MDS) assessment dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. Review of Resident #15's electronic medical record indicated she was on continuous oxygen at 2 liters per minute via nasal cannula for chronic obstructive pulmonary disease (a progressive lung condition that limits airflow and causes persistent respiratory symptoms such as shortness of breath). Review of Resident #15's care plan revealed she had impaired cognitive function related to dementia, was a supervised smoker, and was required to return all smoking materials to the Activities Department after smoking. Review of a Quarterly Smoking Assessment, dated 02/08/26 documented that Resident #15 required supervision while smoking and that the facility was responsible for storing her lighter and cigarettes. (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of all 27 residents identified as smokers showed that each resident's electronic medical record included a care plan intervention which required them to return all smoking materials to the Activities Department upon reˆentering the building from the smoking patio. An interview was conducted with the facility Activity Director on 04/29/26 at approximately 9:50 AM. She explained that she was aware that multiple residents kept cigarettes and lighters in their possession. She acknowledged that residents were expected to return their smoking materials to her after smoking. However, she stated that ensuring compliance was a work in progress and that she should begin by auditing all residents. An interview was conducted with Staff A, Licensed Practical Nurse (LPN) on 4/29/26 at 11:42 AM. Staff A reported that residents were not allowed to keep cigarettes or lighters. Staff A further stated the smoking materials were stored in a locked box at the nurses' station. A joint interview was conducted with the facility MDS Director and MDS Coordinator on 04/30/26 at approximately 2:51 PM. They explained that the care plan for residents who smoke was standardized for all residents, regardless of their Brief Interview for Mental Status (BIMS) score or individual abilities. They stated that all smoking residents were considered to require supervision, and all smoking materials were to be held by the staff. An interview was conducted with Staff I, CNA on 05/01/26 at approximately 4:55 PM. She explained that, outside of the designated smoking times, a box containing smoking materials was kept at the nursing station. However, she stated that most residents kept their smoking materials, including their lighters. She acknowledged being aware that residents kept cigarettes and lighters in their rooms. A joint interview was conducted with the facility Director of Nursing (DON) and Administrator on 05/02/26 at approximately 8:53 AM. The Administrator stated that residents were only permitted to smoke during designated smoking times and were not allowed to smoke in non-designated areas. They stated they have never observed cigarettes or lighters left unattended in resident's room. The administrator explained the facility was responsible for holding and storing resident's lighters. The DON stated lighters were expected to be turned in after each smoking session and that the smoking box used to store the smoking materials was kept at the nurse's station. A telephone interview was conducted with the facility Medical Director on 05/02/26 at approximately 2:56 PM. He explained that, according to the facility policy, residents were not permitted to keep cigarettes or lighters. He further explained that smoking materials were to be supervised by staff regardless of the residents' BIMS score. He emphasized that no residents were allowed to possess lighters and stated that this restriction had always been the facility policy. He indicated that he was not aware of any residents independently possessing smoking materials. He added that residents with a low BIMS score or those receiving oxygen should not have access to smoking materials, as doing so presented significant safety risk.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observations, record reviews, and interviews, the facility administrative staff failed to utilize all the available resources effectively and efficiently to maintain the facility in a safe manner and ensure the facility's smoking policy was properly implemented and that all residents with smoking materials were adequately and accurately assessed. This failure had the potential to cause serious fire hazards, in particular for 1 resident who was identified to have impaired cognition, dementia, and schizophrenia and active oxygen use with smoking materials in their room (Resident #15).The findings included:An observation of the resident's designated smoking patio was conducted on 4/30/26 at approximately 6:05 PM through 6:30 PM. Resident #15 was observed sitting in her wheelchair with a plastic bag in her lap. Closer observation revealed the plastic bag contained cigarettes and a lighter. An interview was conducted with Staff B, Certified Nursing Assistant (CNA) and the facility Activity Director. They acknowledged Resident #15 required use of a smoking apron while she was smoking. They further stated they were going to remove Resident #15's cigarettes from her possession.Review of Resident #15's medical record revealed she had diagnoses including dementia, schizophrenia, and continuous oxygen. In addition, Resident #15 had a roommate who was also ordered to have continuous oxygen.A joint interview was conducted with the facility Director of Nursing (DON) and the Administrator on 05/02/26 at approximately 8:53 AM. The Administrator stated residents were only permitted to smoke during designated smoking times and were not allowed to smoke in non-designated areas. They further stated they have never observed cigarettes or lighters left unattended in resident's room. The Administrator explained the facility staff were responsible for holding and storing residents' lighters. The DON stated lighters were expected to be turned in to staff after each smoking session and that the smoking box (used to store the smoking materials) was kept at the nurse's station. They further acknowledged this restriction was not being enforced by the staff.An interview was conducted with the facility Medical Director on 05/02/26 at approximately 2:56 PM. He explained that, according to facility policy, residents were not permitted to keep cigarettes or lighters. He further explained that smoking materials were to be supervised by staff regardless of the residents' cognitive levels. He emphasized that no residents were allowed to possess lighters and stated this restriction has always been the facility's policy. He added that residents with cognitive issues or those receiving oxygen should not have access to smoking materials, as doing so presented a significant safety risk to all residents.A follow-up interview with the Activity Director revealed that she was aware that multiple residents kept their cigarettes and lighter with them. She added that some families gave smoking supplies to the residents. She confirmed she was aware the residents were supposed to return the cigarettes and lighter to her after smoking. However, she stated that it is a work in progress and she really should start by auditing all the residents so she could get a better idea of which residents had smoking materials. An interview was conducted with the facility Administrator and DON on 5/2/26 at 3:15 PM, The Administrator stated she identified smoking concerns in August 2025 when she was hired at the facility. She explained at that time residents were smoking whenever they wanted, the fire alarm was not working, and the facility did not have a fire watch. The Administrator confirmed she never brought the smoking issue to the Quality Assurance and Performance Improvement (QAPI) committee and there was no Performance Improvement Plan (PIP) in place. She further stated she did not have any active or completed PIP on any identified quality deficiencies since she was hired. The DON stated it was a work in progress, and they planned to discuss the smoking concerns related to residents' keeping their smoking paraphernalia on their person to the next QAPI meeting.The identified smoking situation resulted in the finding of immediate jeopardy. The facility's Administrator was notified of the Immediate Jeopardy findings on April 30, 2026, at 5:50 PM. Immediate Jeopardy was removed on May 5, 2026, at 3:00 PM, prior to survey exit, when the facility provided evidence of immediate corrective actions, which included:1. On 5/2/26, A Safety Meeting was held with the Safety officer, DON, FA to (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	confirm the fire alarm/Life safety systems status and document recent service activities. Annual inspection was completed less than 2 weeks prior to survey. The fire alarm technician was onsite on 5/1/26 to replace smoke detectors and verified the fire alarm system was in working order.2. On 5/3/26 The Nursing Home Administrator received education on the responsibilities, impact, and best practices of the Quality Assurance and Performance Improvement (QAPI) Coordinator. 3. On 5/3/26 at 10:00 AM, An Ad- Hoc QAPI meeting was conducted to review the Immediate Jeopardy (IJ) Abatement plan and corrective action. The meeting attendees included MD, NHA, DON, Maintenance Director/Safety Officer, Director of Rehabilitation, Social Worker, and the Medical Record Director. During the meeting, the IDT reviewed the actions, and confirmed that corrective measures have been implemented, are effective, and are being monitored. Smoking safety risk added as high priority QAPI item. 4. On 5/2/26, Staff education was initiated. Education included review of the smoking policy and procedure to include how cognitive and behavioral impairments increase fire and safety risk for residents who smoke and apply appropriate supervision and safety measures. All staff are assessed after education with a post test. 68 staff educated at the time of exit. 5.100% Smoking Assessments were updated. 14 residents were assessed as independent smokers with 16 residents including Resident #15 assessed as needing assistance with smoking and requiring facility to maintain possession of smoking paraphernalia.6.100 % room rounds for all residents (Including residents identified as non-smokers) to ensure smoking materials were not present outside of the locked storage box.7. The smoking policy was revised/updated on 05/03/2026 and presented to QAPI on 05/03/2026. Residents who have independent smoking privileges shall be permitted to keep smoking materials in a locked box or drawer. The resident must complete the lock box agreement form and must understand and agree to only possess these items on their person when exiting the facility.On 5/4/26, interviews were conducted with staff confirming they were knowledgeable about the facility Smoking policy and had an understanding of how cognitive and behavioral impairment increase fire and safety risk for residents who smoke and apply appropriate supervision and safety. Interviews revealed that staff were knowledgeable of the smoking binder located at the nurse's stations which identified independent smokers, supervised smokers, and smokers who needed a smoking apron. Staff were knowledgeable of unsafe behaviors and could verbalize the process to follow if they identified a resident with unsafe smoking behaviors, and the importance of intervening immediately and safely, removing hazards, and notifying a supervisor or nurse.On 5/3/26 and 5/4/26, interviews and observations were conducted with residents identified as smokers, verifying they understood the importance of always keeping cigarettes in a locked box or drawer. Independent smokers also stated that when they were in the facility, their cigarettes and lighter were stored in their locked box, or locked drawer.On 5/3/26 and 5/4/26, record reviews were conducted for all residents who smoke. Review revealed 100% of residents identified as smokers had updated smoking assessments. Smoking assessments identified if residents were deemed to be independent smokers or if they required supervision. Care plans were updated and correlated with the new assessments.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to develop, implement and maintain an effective Quality Assurance and Performance Improvement (QAPI) program after identifying residents with smoking material on their person to include a resident with limited cognitive abilities and diagnoses of dementia and schizophrenia and on oxygen. (Resident #15) The facility failed to demonstrate evidence of monitoring after the knowledge of facility policy non-compliance.The findings included:Review of Resident #15's electronic medical record indicated she was on continuous oxygen at 2 liters per minute via nasal cannula for chronic obstructive pulmonary disease (a progressive lung condition that limits airflow and causes persistent respiratory symptoms such as shortness of breath). Review of Resident #15's care plan showed she had impaired cognitive function related to dementia, was a supervised smoker, and was required to return all smoking materials to the Activities Department after smoking. A Quarterly Smoking Assessment, dated 02/08/26 documented Resident #15 required supervision while smoking and that the facility staff were responsible for storing her lighter and cigarettes. Resident #15's Minimum Data Set assessment dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment.Observations of the resident's designated smoking patio were conducted on 4/30/26 at approximately 6:05 PM through 6:30 PM. Resident #15 was observed sitting in her wheelchair with a plastic bag on her lap. Closer observation revealed the plastic bag contained cigarettes and a lighter. An interview was conducted with Staff B, Certified Nursing Assistant (CNA) and the Activities Director. They stated Resident #15 required use of a smoking apron. They stated they were in the process of removing Resident #15's cigarettes from her possession. Review of all 27 residents identified as smokers showed that each resident's electronic record included a care plan intervention which required them to return all smoking materials to the Activities Department upon reˆentering the building after the designated smoking time ended. An interview was conducted with the facility Medical Director on 05/02/26 at approximately 2:56 PM. He explained that, according to the facility policy, residents were not permitted to keep cigarettes or lighters. He further explained that smoking materials were supposed to be supervised by staff regardless of the resident's BIMS score. He emphasized that no residents were allowed to possess lighters and stated that this restriction had always been the facility policy. He indicated that he was not aware of any residents independently possessing smoking materials. He added that residents with a low BIMS score or those receiving oxygen should not have access to smoking materials, as doing so presented a significant safety risk.On 5/2/26 at 3:15 PM, an interview was conducted with the Facility Administrator (FA) and Director of Nursing (DON). The FA stated she identified smoking concerns in August 2025 when she was hired at the facility. She explained that at that time residents were smoking whenever they wanted, the fire alarm was not working, and the facility did not have a fire watch. The FA confirmed she never brought the smoking issue to Quality Assurance and Performance Improvement (QAPI) and there was not a Performance Improvement Plan (PIP) in place. She further stated she did not have any active or completed PIPs on any identified quality deficiencies since she was hired. The DON stated it was a work in progress, and they planned to bring the identified smoking concerns related to residents' keeping their smoking paraphernalia on their person to the next QAPI meeting.The situation resulted in the finding of immediate jeopardy. The facility's Administrator was notified of the Immediate Jeopardy findings on April 30, 2026, at 5:50 PM. Immediate Jeopardy was removed on May 5, 2026, at 3:00 PM, prior to survey exit, when the facility provided evidence of immediate corrective actions, which included:1. On 5/2/26, A Safety Meeting was held with the Safety officer, DON, FA to confirm the fire alarm/Life safety systems status and document recent service activities. Annual inspection was completed less than 2 weeks prior to survey. The fire alarm technician was onsite on (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	5/1/26 to replace smoke detectors and verified the fire alarm system was in working order.2. On 5/3/26 The Nursing Home Administrator received education on the responsibilities, impact, and best practices of the Quality Assurance and Performance Improvement (QAPI) Coordinator.3. On 5/3/26 at 10:00 AM, An Ad- Hoc QAPI meeting was conducted to review the Immediate Jeopardy (IJ) Abatement plan and corrective action. The meeting attendees included MD, NHA, DON, Maintenance Director/Safety Officer, Director of Rehabilitation, Social Worker, and the Medical Record Director. During the meeting, the IDT reviewed the actions, and confirmed that corrective measures have been implemented, are effective, and are being monitored. Smoking safety risk added as high priority QAPI item. 4. On 5/2/26, Staff education was initiated. Education included review of the smoking policy and procedure to include how cognitive and behavioral impairments increase fire and safety risk for residents who smoke and apply appropriate supervision and safety measures. All staff are assessed after education with a post test. 68 staff educated at the time of exit.5.100% Smoking Assessments were updated. 14 residents were assessed as independent smokers with 16 residents including Resident #15 assessed as needing assistance with smoking and requiring facility to maintain possession of smoking paraphernalia. 6.100 % room rounds for all residents (Including residents identified as non-smokers) to ensure smoking materials were not present outside of the locked storage box.7. The smoking policy was revised/updated on 05/03/2026 and presented to QAPI on 05/03/2026. Residents who have independent smoking privileges shall be permitted to keep smoking materials in a locked box or drawer. The resident must complete the lock box agreement form and must understand and agree to only possess these items on their person when exiting the facility.On 5/4/26, interviews were conducted with staff confirming they were knowledgeable about the Smoking policy and had an understanding of how cognitive and behavioral impairment increased fire and safety risk for residents who smoke and apply appropriate supervision and safety. Interviews revealed that staff were knowledgeable of the smoking binder located at the nurse's stations which identified independent smokers, supervised smokers, and smokers who needed a smoking apron. Staff were knowledgeable of unsafe behaviors and were able to explain the process if they identified a resident with unsafe smoking behaviors, and the importance of intervening immediately and safely, removing hazards, and notifying a supervisor or nurse.On 5/3/26 and 5/4/26 interviews and observations were conducted with residents identified as smokers, verifying they understood the importance always keeping cigarettes in a locked box or drawer. Independent smokers also stated when they were in the facility, their cigarettes and lighter were stored in their locked box, or locked drawer.On 5/3/26 and 5/4/26 record reviews were conducted for all residents who smoke. Review revealed 100% of residents identified as smokers had updated smoking assessments. Smoking assessments identified if residents were deemed to be independent smokers or if they required supervision. Care plans were updated and correlated with the new assessments.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide the required bathing and shower services necessary to maintain residents' overall personal hygiene for 6 out of 6 residents reviewed (Residents #4, #10, #38, #81, #98, #108).The findings include:1. During interviews conducted on 4/27/26 at 11:45 AM and 4/28/26 at 08:25 AM, Resident #4 revealed he needed assistance to get out of bed, and his preference was to get out of bed. He stated, I want to get up in my wheelchair, but the staff are busy. He stated he had asked to get out of bed plenty of times, but it doesn't happen unless he had physical therapy. He stated he got bored lying in bed. He stated he would watch his roommate's television, but watching TV was not something he enjoyed. Resident #4 stated he did not receive a bath every week, and he was not given a choice for a shower or bath by the staff. Observations conducted on 4/28/26 at 8:25 AM, 12:02 PM, and 3:40 PM, on 4/29/26 at 6:25 AM,11:14 AM, and 5:00 PM and 4/30/26 at 8:25 AM revealed Resident # 4 lying in bed dressed in a hospital-type gown. At the time of the observations, interviews were conducted with Resident #4, confirming he had not gotten up, no one had asked him if he wanted to get dressed, or offered to get him out of bed. He stated, It doesn't matter if I ask them to get up or not. A review of Resident #4's medical record revealed he was admitted to the facility on [DATE]. Resident #4's medical diagnoses included hemiplegia and hemiparesis following a stroke, neurocognitive disorder, and depression. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident# 4 required extensive assistance to transfer from the bed to a chair and was dependent on staff for showering or bathing. The MDS also confirmed Resident #4 did not reject care. A review of Resident #4's care plan revealed Resident #4 liked to attend activities of interest, such as monthly birthday parties and special events. It indicated he should be invited to these activities. The care plan reminded and encouraged the staff to provide Resident #4 assistance so he could attend these events. Further review of the care plan revealed Resident #4 had a self-care deficit related to left-sided hemiparesis. A review of Resident #4's admission MDS revealed his preferences included keeping up with the news, doing things with groups of people, going outside to get fresh air, and listening to music. The MDS further indicated it was somewhat important for Resident #4 to choose what clothes to wear and to choose between a shower, bed bath or a sponge bath. On 4/30/26, a review of the documentation for Activities under tasks revealed no documentation for activities or activities participation except on 4/20/26 at 6:35 AM, which stated Not Applicable. A review of Shower/Bath documentation revealed Resident #4 did not have a shower or bath documented for 14 days between 3/31/26 and 4/14/26. (photographic evidence obtained) An interview was conducted with Staff P, Certified Nursing Assistant (CNA) on 4/30/26 at 8:40 AM. Staff P stated Resident #4 would usually ask to get up, but that he had not asked that week. She further stated Resident #4 would refuse to get up or would ask to go back to bed immediately after getting up. Staff P admitted she had not asked Resident #4 this week if he would like to get out of bed. When Staff P asked Resident #4 if he would like to get dressed, and get up, and he replied, I will get up anytime. An interview was conducted with Staff K, Licensed Practical Nurse (LPN) on 4/30/26 at (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	approximately 9:10 AM. Staff K explained Resident #4 did not tolerate being out of bed for very long, and after a couple of hours he wanted to go back to bed. She further stated they tried to get all residents up unless they refused, and the expectation was for the CNAs to ask all residents if they wanted to get up, get dressed, and if they preferred a shower or bath. An interview was conducted with the Facility Administrator on 5/1/26 at approximately 2:30 PM. The Administrator stated she expected the CNAs to ask residents if they wanted to get out of bed. She further stated, it is on a case-by-case basis, and some of the CNAs knew the residents very well and knew if the residents wanted to get up or not. 2. On 04/27/2026 at 11:45 AM, Resident #10 reported that she had not received a good shower in about a month. She said she had only been given a few baths, which did not make her feel clean. She stated that staff had recently informed her the showers were out of service. A review of Resident #10's bathing record revealed she had received four baths in the past 30 days. An interview was conducted with the Facility Maintenance Director on 04/28/2026 at 9:23 AM. The Maintenance Director reported that only one shower in the E hallway was available for all residents. The D hallway shower room had been out of service for two weeks and the facility is currently awaiting funding approval. The B hallway shower room had been out of service for one week for floorˆtile repairs but was back in service as of 04/27/2026. 3. An interview was conducted with Resident #38 on 04/27/2026 at approximately 10:50 AM. Resident #38 expressed concerns regarding hygiene care, stating she had not received her scheduled showers. She stated she had been informed that the showers were out of service for maintenance. She stated that her last shower was over a week ago. A review of Resident #38's medical record revealed diagnoses of functional quadriplegia (severe physical frailty, requiring total care for daily activities) with significant weakness. Her scheduled shower days were noted to be Wednesdays and Saturdays. There was no recorded documentation for showers being provided to Resident #38 between 04/06/2026 and 04/12/2026 (Photographic evidence obtained). Resident #38 was care planed for activity of daily living self-care deficit related to weakness and impaired mobility with interventions to assist to shower/bathe twice a week. 4. An interview was conducted with Resident #81 on 04/27/2026 at 2:45 PM. Resident #81 stated they did not receive 3 baths per week from the staff. On 4/27/26 a review of the Certified Nurse's Aides (CNA) Tasks form was conducted for Resident #81. Documentation showed that the resident had only had 2 baths in the past 30 days, on 4/13/26 and 4/24/26. There was no documentation noted of refusals or the resident not being available. An interview was conducted with Staff K, Unit Manager on 4/29/26 at approximately 2:23 PM. Staff K stated it was the responsibility of the Director of Nursing, the Minimum Data Set (MDS) coordinator, and unit managers to enter the CNA tasks into the resident's electronic medical records. Staff K stated the nurses were responsible for ensuring care was delivered and documented in the tasks. Staff K independently reviewed Resident #81's medical record and verified the bathing task was not completed and further verified Resident #81 only received 2 baths in the past 30 days. She stated, based on the documentation, it did not look like Resident #81 received her baths. Staff K stated there has been some confusion as the facility had recently switched to a new bath form and not all staff (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were using the correct form. Staff K stated the CNAs were supposed to document in the electronic record and the nurses were supposed to verify and sign off on the care. 5. An interview was conducted with Resident #98 on 04/27/2026 at 12:20 PM. Resident #98 reported she had not received a bath in more than two months and had not had a shower in two years. Resident #98 stated that she preferred showers and preferred to have them done in the daytime. She explained that staff often deferred her bathing to the next shift, and the next shift did not follow through. She also noted that she required the use of a Hoyer lift for getting out of bed and the staff frequently told her she needed two staff for assistance, which delayed her bathing further. A review of Resident #98 's electronic medical record revealed she had 2 documented baths in the last 30 days. A follow-up interview was conducted with Resident #98 on 05/02/2026 at 9:52 AM. Resident #98 revealed she has not had a bath or shower at all this week. Review of the bath book showed that Resident #98 had a bed bath on 4/29/2026 at night, yet she stated that she did not have one. Resident #98 stated, sometimes they wipe my legs and the back of my neck, but it is not a bath. She stated that she would like to get into the shower and had expressed this to the staff. During an interview with Staff W, a Certified Nurse Assistant (CNA), on 5/02/2026 at 3:34 PM, at Resident #98's bedside, Staff W indicated that baths are documented in the resident's electronic chart after they are completed and should be documented on the bath sheets at the nurse's station. Staff W also confirmed Resident #98 's statement that she has not had a proper bath at all the past 5 days. 6. On 04/28/2026 at 8:20 AM, Resident #108 was observed in her room, sitting in her wheelchair, wearing a facility gown. Resident #108's hair appeared disheveled. An interview was conducted with Resident #108 at this time. Resident #108 stated she had not received a bath since her admission on [DATE]. An interview was conducted with Staff S, Registered Nurse Supervisor on 04/28/2026 at 8:45 AM. Staff S confirmed Resident #108 was scheduled for a bath on Wednesdays and Saturdays. Staff S independently reviewed the bath logbook and confirmed there was no bath documented for 04/18/26, 04/22/26, or 04/25/26. Review of Resident #108's electronic medical record was conducted. The task section for bathing for the past 14 days revealed Resident #108 did not receive a bath on scheduled dates of 04/18/2026, 04/22/2026, 04/25/2026. Resident #108's care plan revealed she had an Activities of Daily Living (ADL) deficit related to weakness and impaired mobility and staff was instructed to provide assistance with mobility and ADLs. The care plan goal documented was for Resident #108 to be clean, odor free, and appropriately dressed daily.

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	105628	A. Building B. Wing	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arabella Health & Wellness of Pensacola	1717 W Avery St Pensacola, FL 32501

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, record review, and policy review, the facility failed to ensure consistent implementation of its grievance procedures and failed to document, investigate, track, and follow up on resident grievances in accordance with facility policy for a resident grievance in 2 of 2 grievances reviewed. (Residents #54 and #10) The findings include:On 04/27/2026 at approximately 10:45 AM, an interview was conducted with Resident #54. Resident #54 stated there was an occurrence about a month ago where his clothing items did not return from the laundry. Resident #54 stated his clothes were marked with his name and that he had at least two other occurrences of lost clothing items since admission to the facility. Resident #54 stated he reported his missing clothing items to two unnamed staff members with a reply they would report to the social worker and management. Resident #54 stated he did not receive further information about his missing clothing items.On 04/27/2026 at approximately 11:00 AM, an interview was conducted with Staff BB, a Certified Nurse Assistant (CNA). Staff BB stated that, if a resident informed her of missing clothing items, she reported to the Charge Nurse or Social Worker. Staff BB stated she was not aware of how to obtain or assist a resident with a grievance form.On 04/29/2026 at approximately 1:10 PM, an interview was conducted with the Director of Social Services and the Administrator. The Administrator stated the Director of Social Services is the primary person responsible for grievance management. The Administrator stated Resident #54 had not reported missing items to her. The Director of Social Services stated she had worked at the facility for six weeks and was not aware of a grievance by Resident #54.On 04/29/2026 at approximately 4:30PM during the Resident Council Meeting, Resident #10 stated the charger for her wheelchair was missing and stated a staff member took it. When asked if she reported a grievance, Resident #10 stated she informed the facility and was told they would not pay for it. The Director of Social Services stated they did a search and would order Resident #10 a new charger. The Director of Social Services stated she had not written a grievance about the issue.A review of the facility's grievance logbook for 2025 and 2026 was conducted. It was confirmed that the logbook did not contain grievances for Resident #54 and #10.Review of facility's policy titled, Grievances/Complaints, last revised April 2008, contained the following: Grievances and/or complaints may be submitted orally or in writing. The Administrator has delegated the responsibility for grievance and/or complaint investigation to the Social Services Director. Upon receipt of a grievance and/or complaint, Social Services will investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint. The policy also indicates the resident will be informed of the findings and actions within ten (10) working days.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews, record review and facility policy review, the facility failed to revise the comprehensive care plan to reflect a significant change in condition for 1 of 1 record reviewed for care plan revision (Resident #38).The findings include:A review of Resident #38's hospital record dated 04/21/2026 at 12:05 AM revealed that Resident #38 was diagnosed with acute urinary retention and constipation related to neurogenic bowel. This was not reflected in any of her care plansOn 04/27/2026 at approximately 10:50 AM, an interview was conducted with Resident #38. She explained that, in the past, episodes of constipation would lead to urinary retention requiring self-catheterization.On 04/30/2026 at approximately 2:51 PM, an interview was conducted with the MDS Director and MDS Coordinator. They explained that care plans were revised following hospitalizations and with any change in condition requiring adjustments to a resident's plan of care. They stated that they were not aware that Resident #38 had been transferred to the hospital. They acknowledged that the care plan should have been updated to reflect Resident #38's new diagnosis, including appropriate interventions and monitoring to address Resident #38's needs. They further acknowledged that this was an oversight and stated that the care plan should have been updated to ensure coordinated and individualized care following the change in condition.The facility policy titled: Care Plans-Comprehensive revised 09/21/03 was reviewed. It stated, The Comprehensive care plan is based on a thorough assessment. Each residence comprehensive care plan is designed to incorporate identified problem areas; risk factors associated with identified problems; reflect treatment goals timetables and objectives and measurable outcomes; aid in preventing or reducing declines in the residence functional status; reflect currently recognized standards of practice for problem areas and conditions. It also identifies problem areas in their causes, develops interventions that are targeted and meaningful to the residents. The process requires careful data gathering, proper sequencing of events and complex clinical decision making. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents condition change.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and review of the facility policies, the facility failed to provide proper assessment and assistance in urinary/catheter care for 2 of 2 residents reviewed for urinary care (Resident #5 and #38). The findings included:1. A review of Resident #5's electronic medical record was conducted. On 4/24/26 at 8:03 PM, Staff V, Registered Nurse (RN), documented that Resident #5 requested transfer to the local Emergency Department due to a possible Urinary Tract infection (UTI). Staff V entered a transfer order under the medical director's name. Further review of the record revealed there was no documentation of a physical assessment being performed and no evidence that the medical director was notified of the transfer.Review of Resident #5's progress notes showed no documentation of a resident assessment, no interview regarding signs or symptoms, and no indication that staff offered any alternatives other than transfer to the emergency room.Review of Resident #5's transfer document dated 04/24/26 at approximately 8:03 PM revealed the physicianˆnotified field was left blank by the staff.An interview was conducted with Staff AA, RN on 5/1/26 at 12:11 PM. Staff AA stated that when a resident reports symptoms of a UTI, the nurse completes and documents an assessment and notifies the physician. She added that, if the physician or nurse practitioner is unavailable or it is after hours, the staff use the afterˆhours tablet to contact the onˆcall provider.An interview was conducted with the facility Director of Nursing (DON) on 05/01/26 at 1:50 PM. The DON confirmed the facility's procedure for transferring a resident to the emergency room included assessing the resident, notifying the provider, and documenting the process in the electronic record.An interview was conducted with the facility Nurse Practitioner (NP) on 05/01/26 at 2:16 PM. The NP independently reviewed Resident #5's chart and confirmed that Staff V entered the transfer order under the medical director's name. He clarified that the medical director was not on call at that time because it was after hours and stated that staff were instructed to follow the afterˆhours protocol, which included using the tablet to contact the on-call provider.A telephone interview was conducted with Staff V on 05/02/26 at 2:43 PM. Staff V stated she did not remember which physician was contacted regarding Resident #5's UTI concerns and subsequent request for transfer. She reported that another nurse assisted her, but she did not recall who it was. She further stated she did not remember asking the resident about specific symptoms or performing a physical assessment prior to transferring her to the hospital.A telephone interview was conducted with the Medical Director on 05/02/26 at 2:57 PM. The Medical Director reported he did not recall any notification regarding Resident #5's UTI symptoms or transfer request on 04/24/26. He stated he was generally not contacted after hours because the facility had access to an after-hours on-call program.In an interview conducted on 05/02/2026 at 3:00 PM with the facility DON and Administrator, documentation was requested verifying that an on-call provider was contacted for Resident #5 on 04/24/26. The DON and Administrator confirmed they reviewed the after-hours contact log and did not find documentation to show the on call provider was contacted on 04/24/26. 2. An interview was conducted with Resident #38 on 04/27/26 at approximately 10:50 AM. She explained that, in the past, episodes of constipation have led to urinary retention requiring self-catheterization (a procedure in which a thin, flexible, single-use tube is inserted into the bladder through the urethra to drain urine. The tube is removed immediately after the bladder is empty). She explained that, on the evening of 04/20/26 she was experiencing pain because she was unable to urinate. She notified the nurse, explained her medical history, and requested straight catheterization. She further stated that, at first, the nurse told her that she will be back; however, after a few hours, Resident #38 reported that the nurse informed her that straight catheterization was not an option. She further stated that, due to her increasing discomfort, she could not wait any longer and requested to be transferred to the local hospital to receive the care she needed.A review of Resident #38's electronic medical record revealed Resident #38 requested to be transferred to the hospital on [DATE]. During review of physician (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders, it was noted that an order was electronically created and confirmed by Staff G, Licensed Practical Nurse (LPN) to send (Resident #38) to the hospital for further evaluation related to the resident not voiding for 24 hours. This was written as a verbal order from the facility's medical director, dated 04/20/26 at 9:39 PM.A review of a nursing progress note written by Staff G on 04/20/26 at 9:43 PM, revealed that Resident #38 stated she had not voided in 24 hours and requested to be straight catheterized. After reporting to the facility's Administration, she notified Resident #38 that straight catheterization was not an option. Resident #38 then stated she wanted to go to urgent care to be seen because of the discomfort she was experiencing.A review of the Emergency Medical Transport record dated 04/20/26 revealed Resident #38 was unable to void and stated she needed to be straight catheterized and is supposed to get Miralax (over the counter laxative to treat constipation), which she is not receiving. The record further noted that Resident #38's abdomen was distended upon assessment.A review of Resident #38's emergency room hospital record dated 04/20/26 at 11:06 PM revealed that Resident #38 presented to a local emergency room and received a urinary catheter insertion which resulted in 450 milliliters of urinary output (considered a full bladder). Resident #38 was diagnosed with acute urinary retention and constipation related to neurogenic bowel. The Emergency Department physician's note revealed that Resident #38 reported to the emergency room staff that the facility will not do a foley catheter.An interview was conducted with Staff G on 04/30/26 at approximately 10:25 AM. Staff G confirmed she was assigned to care for Resident #38 on 04/20/26. She explained that Resident #38 reported to her that she had not voided for 24 hours and requested straight catheterization. Staff G indicated that she informed Resident #38 that a provider order was required to perform a straight catheterization. She continued, saying she told Resident #38 that she could wait for the next day to see the Nurse Practitioner (NP) on site. She acknowledged that she did not document a nursing assessment of Resident #38's change in condition. She stated that the regular provider was not contacted since it was after hours but said she had called the after-hours telehealth provider per facility protocol. Staff G further stated, she did not document the communication. She explained that Resident #38 requested to be transferred to the hospital to be straight catheterize after not voiding for 24 hours. She confirmed that straight catheterization is within her scope of practice as a licensed practical nurse and that catheterization kits are available within the facility.A joint interview was conducted with the facility's Administrator and the DON on 04/30/26 at approximately 11:30 AM. They explained that after hours, the facility utilizes a contracted provider telehealth system for clinical needs and orders. The DON explained that the facility nurses have the capability to perform straight catheterization, and that kits were available in the medication storage cabinet. She further stated that this task is within the scope of practice for a licensed practical nurse. She recalled reminding Staff G, LPN that straight catheterization requires a physician order. Upon independent review of Resident #38 electronic medical record, the DON confirmed that the resident was transferred to the hospital due to urinary retention without a documented nursing assessment, without documented communication with the provider to support the need for transfer, and without evidence that Resident #38 needs could not be met at the facility. She added that the decision to transfer Resident #38 did not make sense, as the facility had the capability to perform the procedure. She stated that the facility also maintains an on-call contract for bladder scanning service as needed, which was also not utilized. She acknowledged that no alternative interventions, including in-house catheterization, were offered to Resident #38 prior to the hospital transfer. She further indicated that it was her expectation that a nursing assessment would be documented in the medical record and a change of condition would be communicated to the provider. The DON stated that a miscommunication breakdown lead the Resident #38 not being appropriately assessed.An interview was conducted with the NP on 04/30/26 at 12:21 PM. He explained that he expected nursing staff to be held accountable for adherence to nursing standards. He acknowledged that a nursing assessment should have been documented and that a provider order for straight catheterization could have been obtained to address the resident symptomatic urinary retention (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without a hospital transfer.A follow-up joint interview was conducted with the Administrator and the DON on 05/02/26 at approximately 10:10 AM. The Administrator stated every provider telehealth consult was generated and electronically signed. She was unable to retrieve the record of any telehealth communication regarding Resident #38 on 04/20/26. She added that she contacted the telehealth provider company that had no record of being contacted that night.A follow up interview was conducted with the NP on 05/02/26 at approximately 11:30 AM. He indicated that it was his expectation for the clinical staff to contact and report a change of condition to a provider and obtain appropriate orders.A telephone interview was conducted with the Medical Director on 05/02/26 at approximately 2:56 PM. He explained that after hours, the facility utilized the contracted telehealth system for on-call needs and orders, including transfer orders. He didn't recall receiving a call regarding Resident #38 and stated that nurses must talk to the on-call provider to obtain appropriate orders when needed, including transfer order. He explained that nursing staff were responsible for contacting the on-call provider to obtain necessary orders. He further indicated that the facility has the capability to perform straight catheterization for urinary retention and didn't understand why the nursing staff did not contact the on-call provider to obtain an order in this instance. He reiterated that staff are expected to communicate with the on-call provider to obtain appropriate medical orders when needed.Review of the facility's Licensed Practical Nurse job description was conducted. Nursing care functions include performing continual observation and evaluation of each resident's physical, cognitive and emotional status; communicating timely with physicians and/or nurse practitioners related to resident care needs and concerns. Be responsible for implementing and communicating to other caregivers all physician and/or nurse practitioners orders; Document all clinical information in an informative and descriptive manner that reflects the care provided to the residents as well as the residents response to the care. Must be able to relate information concerning a resident's condition.The Facility's Assessment Tool (the evaluation used to determine the facility's resources, staff competencies, and ability to meet resident's care needs) updated 03/23/26 was reviewed. The tool indicated, Services and Care offered based on Resident's Needs revealed the facility offers intermittent or indwelling or other urinary catheter.The facility policy titled: Transfer or Discharge, Emergency, dated 2001 was reviewed. It indicated, Our facility shall make an emergency transfer or discharge when it is in the best interest of a resident. The policy indicated the facility staff would notify the residents' Attending Physician of any change in condition, transfer, or discharge.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, interviews, and record review, the facility failed to monitor weights for 1 of 1 resident reviewed for significant weight loss (Resident #13).The findings included: An observation was conducted on 04/28/26 at 8:00 AM of Resident #13 eating her breakfast meal. She appeared thin. She stated that, since she was in the hospital, she had not had much of an appetite but that she was trying to eat. It was noted that there were no supplements present on her meal tray.Record review revealed that Resident #13 weighed 172.2 pounds on 10/13/25. However, on 04/13/26, Resident #13 weighed 145 pounds. This indicates Resident #13 suffered a 15.8% weight loss in 6 months.An interview was conducted with the facility Dietary Manager on 04/29/26 at 2:39 PM. The Dietary Manager revealed that Resident #13 had orders for nutritional supplements three times per day and Liquid Protein supplements 30 milliliters for nutritional needs. The Dietary Manager stated Resident #13 was on a mechanical soft diet and had been changed to a regular diet with thin consistency. She acknowledged that Resident #13 was hospitalized and had lost a lot of weight.An interview was conducted with Resident #13 on 04/30/26 at 10:24 AM. Resident #13 revealed she did not recall receiving any supplements with her meals. She recalled she received some ice cream one time.Review of Resident #13's progress notes revealed an order from the Registered Dietitian stating that Resident #13 was supposed to receive weekly weights. However, closer review of Resident #13's medical record revealed there were no weekly weights documented. On 05/01/2026 at 10:23 AM, a follow up interview with the Dietary Manager was performed concerning the weekly weights. She mentioned that Resident #13 was recently hospitalized for 4 days, but made no mention of why the ordered weekly weights were not followed up on by herself. An interview was conducted with Staff G, Licensed Practical Nurse (LPN) on 05/01/26 at 10:36 AM. She acknowledged that the ordered weekly weights were not done. She stated that Staff EE, Restorative Certified Nursing Assistant, was responsible for taking and documenting the residents' weights.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews and review of facility policy, the facility failed to ensure the accurate and periodic reconciliation and proper disposal of controlled medications.The findings included:Review of the controlled substance destruction records was conducted on 04/29/26 at approximately 9:34 AM with the facility Director of Nursing (DON) and the Administrator. The double locked drawer where discontinued narcotics were stored was noted to be full. Review of the logbook revealed that the last documented destruction of narcotics occurred on 11/06/25. Further review identified that only one out of six pages of the destruction log contained the required witness signature to validate the destruction process and ensure accountability.A joint interview was conducted with the DON and the Administrator on 04/29/26 at approximately 9:34 AM. They reported that all discontinued narcotics were stored in a double locked drawer located in the DON's office and acknowledged a significant accumulation of discontinued controlled substances. The DON stated that, since her hire in December 2025, she had not conducted any narcotic destruction. They independently reviewed the narcotic destruction logbook and confirmed the last documented destruction occurred on 11/06/25 and only one out of 6 pages contained the required witness signature to validate the destruction process and ensure accountability. They acknowledged that this process was not completed in accordance with facility policy and recognized the importance of conducting narcotic destruction at regular intervals to maintain compliance and ensure safe handling of controlled substances.Review of the facility policy titled: Discarding and Destroying Medications dated 2001 and last revised in 2014 was conducted. Schedule II, III, and IV controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous controlled medications. The facility may contract with a DEA registered collector for proper disposal of non-hazardous schedule II, III, IV and V controlled substances. If a resident is transferred to another facility or dies while he or she is in lawful possession of the controlled substances, the facility may dispose of the controlled substance(s) by depositing in the authorized on-site collection receptable. Disposal of controlled substances must take place immediately (no longer than 3 days) after discontinuation of use by the resident. The steps for destruction include taking the medication out of the original containers, mix medication, either liquid or solid, with an undesirable substance, sand, coffees, kitty litter, or other absorbent materials. Dispose with the solid waste in the presence of two witnesses. Document the disposal on the medication disposition record and include at least the signature of two witnesses. The medication disposition record will contain the following information:The resident's name;Date medication disposed;The name and strength of the medication;The name of the dispensing pharmacy;The quantity disposed;Method of disposition;Reason for disposition, and;Signature of witnesses.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and facility policy review, the facility failed to ensure medications were under direct observation of the person administering the medications during 1 medication administration observations conducted for Resident #109.The findings included:A medication administration opportunity was conducted with Staff Y, Licensed Practical Nurse (LPN) on 04/29/26 at approximately 7:45 AM. Staff Y was observed preparing to administer medications to Resident #109. During the process of removing medications from a medication bubble pack, 4 pills fell outside of the medication cup and onto the top surface of the medication cart. 3 of the 4 medications were for Resident #109's heart condition. Staff Y acknowledged the 4 tablets fell onto the medication cart and did not immediately secure or dispose of the dropped medications. Rather, Staff Y pushed the 4 pills aside on the medication cart next to the computer (Photographic evidence obtained). Staff Y then locked the medication cart and entered Resident #109's room, leaving the unsecured pills on the top of the cart and out of her direct sight. During this time, other residents were observed self-propelling in wheelchairs in the hallway, with potential access to these unsecured medications.An interview was conducted with Staff Y on 04/29/26 at approximately 8:17 AM. She confirmed that she did not have direct oversight of the medication cart or the unsecured pills while in Resident #109's room. She acknowledged that residents were present in the hallway and that some had a history of confusion. Staff Y further confirmed that leaving medications unsecured on top of a medication cart could allow unauthorized access to dangerous medications, which had the potential to cause harm if a resident were to ingest them.An interview was conducted with the facility Director of Nursing (DON) on 05/01/26 at approximately 3:50 PM. She explained that it was not acceptable for staff to leave medications unattended and this did not meet the facility's expectations of the nursing staff. She acknowledged that some residents were cognitively impaired and that unattended medications posed a safety risk.Review of the facility policy titled: Administering Medications (dated 2001 and revised 12/2012) was conducted. It stated that no medications were kept on top of medication carts. The cart must be clearly visible to the personnel administrating medications, and all outward sides must be inaccessible to residents or others passing by.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to use appropriate personal protective equipment (PPE) during patient care involving 2 of 2 residents with indwelling medical devices to prevent contamination and reduce infection risk (Resident #5, Resident #33)The findings included: An interview was conducted with Resident #5 on 04/27/26 at 11:17 AM. Resident #5 reported that staff do not wear the gowns provided for use during catheter care. Resident #5 further stated that sometimes staff wash their hands. During this interview, it was noted that Personal Protective Equipment (PPE) gowns were located on a hanging organizer on the back of Resident #5's door. It was also noted that signage mandating PPE equipment and EBP sign was present on Resident #5's door. During an observation conducted on 04/29/26 at 10:06 AM, Staff T, Certified Nurse Assistant (CNA) performed catheter care on Resident #5. Staff U, CNA assisted Staff T with the catheter care. Staff T and Staff U performed hand hygiene and wore gloves; however, PPE gowns were not used by the staff. When questioned about Enhanced Barrier Precautions (EBP), Staff T and Staff U incorrectly referenced barrier cream and skin prep rather than PPE requirements, such as gloves and gowns. Staff X, Licensed Practical Nurse (LPN) was also present during this catheter care observation and stated that PPE gowns were required when providing care to a resident with a catheter. An interview was conducted with the facility Director of Nursing (DON) on 05/01/26 at approximately 10:45 AM. The DON stated staff were expected to wear PPE when providing care to residents with wounds or indwelling medical devices such as catheters. She explained that staff had been educated on catheter care and proper use of PPE. The DON provided a binder containing staff signatures confirming completion of this education. Review of the binder showed that Staff T signed a PPE competency form on 02/20/26; however, the form was blank, with no indication that a demonstration was performed. Staff U had a PPE competency form indicating successful demonstration, also signed on 02/20/26. An interview was conducted with Staff S, Interim Infection Prevention Nurse on 05/02/26 at 8:45 AM. Staff S revealed that EBP had been an established expectation in longˆterm care since approximately 2023. She confirmed that staff were required to wear appropriate PPE when providing care to residents with indwelling medical devices, such as catheters. 2. An observation was conducted of Resident #33's room on 04/27/26 at 10:44 AM. A sign for EBP was present on the door to Resident #33's room. Staff I, CNA and Staff Z, CNA were both wearing gloves and Staff Z was holding a full trash bag. it was noted that Staff I and Staff Z were not wearing protective gowns. During this observation, an interview was conducted with Staff I and Staff Z. Staff Z confirmed they just completed incontinent care on Resident #33. When asked about the sign for EBP, Staff I stated she did not know whether Resident #33 was still on EBP. When asked if Resident #33 had a catheter, Staff I replied, yes. When asked if staff should wear a gown and gloves when providing incontinent care to Resident #33, Staff I responded, I wore gloves. Review of Resident #33's electronic medical record revealed a provider's order for Enhanced Barrier Precautions related to suprapubic catheter was entered on 04/11/26 at 1:07 PM. Enhanced Barrier Precautions were also documented in Resident 33's care plan under suprapubic catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105628	A. Building B. Wing	05/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arabella Health & Wellness of Pensacola	1717 W Avery St Pensacola, FL 32501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Resident #33 on 04/27/26 at 2:10 PM. Resident #33 stated the staff wore gloves when providing catheter care or incontinence care but that they did not always wear gowns. An interview was conducted with the DON on 04/27/26 at 3:00 PM. The DON confirmed the staff should follow the EBP instructions and wear a gown and gloves when providing incontinent care to a resident with a catheter who has an order for EBP.