

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106081	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Arabella Health & Wellness of Carrabelle		STREET ADDRESS, CITY, STATE, ZIP CODE 239 Crooked River Road Carrabelle, FL 32322	
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, clean, and sanitary environment at 1 of 4 hallways, 1 of 2 nurses' stations, 2 resident rooms (room [ROOM NUMBER] and room [ROOM NUMBER]), 1 laundry room, and 2 of 2 shower rooms. The findings include: Hallways: On 3/9/26 at 12:30 PM, an observation of the 400-unit hallway noted a hole in the hallway above the baseboard in between rooms [ROOM NUMBERS]. Equipment was observed sitting in the back hallway that consisted of 2 bed frames, 3 mattresses, and 2 mechanical Hoyer lifts. The handrail on the 400-unit right side has 2 areas on the corners that were missing. Nurses' stations: A large brown and yellow color stain was observed on the ceiling of the nurses' station extending from the metal vent across the ceiling to the curve of the nurses' desk where hallway splits into sections. The trim across the nurses' station desk is broken in several areas and has sharp edges where trim has broken off. The metal vent above the nurse's station appears to have a rusted like appearance, with a blackish color film on the vent grates. Resident rooms: room [ROOM NUMBER]'s bathroom has a black color film at the base of the toilet with an appearance of rust on the handrails. room [ROOM NUMBER] has a rust on the vent grates in the bathroom with a blackish film on the floor at the base of the toilet. Inside room [ROOM NUMBER], a brown color stain was observed with a small hole in the ceiling over the door side bed of the resident. Laundry room: On 03/11/26, an observation of the facility's laundry room was conducted at 09:30 AM. Buckets were sitting in the sink with a spoon sitting next to the faucet handles. A rusted bookshelf was sitting against the right side of the wall, with brooms, dustpans, and a bucket blocking access to the eye wash station. Two maintenance ladders were leaned up against the left side of wall upon entry to the laundry area. The ceiling has the appearance of peeling paint, greyish color stains, rusted like appearance on the door hinges leading to the outside. Rusted grates behind the washing machines were noted with paint peeling on the wall directly above it and has the appearance of water damage along the baseboards extending from the right to the left side and on the wall directly above the floor. While doing this observation, Staff Member H (Laundry Aide) stated, Don't step off the cement or you will fall through the grates in the back. Peeling paint from the ceiling with the appearance of water damage surrounding the light fixture in room was noted. The linen closet's back wall has an interior covering peeled away from the wall. Staff Member H stated, The leaks and water damage has been like that since about 5 months ago. Shower rooms: On 3/11/26 at 10:45 AM, an observation was conducted on the Unit 300-400 shower room. A hole in the wall behind the door was observed with broken tile and the wall inside was exposed. The last shower stall had paint peeling from the ceiling. Wet, soiled towels were laying on (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the floor in a shower stall. A shower bed with a foam pad sitting in the bathroom area blocked the toilet. The shower bed pad has visible tears on the top surface of the pad and the bottom side of the shower pad. Upon lifting up the foam pad from the shower mesh bed, visible debris was noted. Staff Member F (a Certified Nursing Assistant, CNA) entered the shower room. An interview was conducted that revealed, upon asking how long the hole in the wall has been there, Staff F stated, I am not sure, a while now. He then stated, Are you all here to help us get these things fixed around here, we sure need it. When asked how often staff cleans the shower chairs, shower beds, and pads, he stated, we are supposed to do it after each use. On 3/11/26 at 11:00 AM, an observation of the shower room for halls 100 and 200 revealed a tub that sits on the right-hand side of the shower room that has trash and a pair of shoes and a pair of boots sitting in the tub. The inside of the tub is visibly dirty with a greenish color film noted around the top of the tub near the drain, rusted shower curtain hooks hanging on 2 shower stalls, and black tape on one of the arms of a shower chair noted. The shower chair had a black color substance noted around the screws and connections. A black substance on the tile floor in a shower stall with a greyish color build up on the shower bench legs. Upon exiting the shower room, a shower bed was noted with a foam pad noted in the doorway of a resident's room with visible tears in the foam pad. A black color substance was observed on the rails of the shower bed at the top. Upon lifting the foam pad up from the shower mesh bed, tears in the pad were noted on the bottom side of pad, along with discoloration and the mesh bed has visible debris observed. The Assistant Director of Nurses was interviewed. She stated, The shower beds are cleaned after each use. She is not sure how often the shower pads are replaced. An interview was conducted with the Maintenance Director on 3/11/26 at 11:00AM. He stated that all the equipment in the back hallway was broken, and they have no storage area to store equipment until it can be discarded. He stated that he is trying to repair as he can, but many of the issues existed before he came on board. An interview with the Administrator was conducted on 3/11/26 at 02:30 PM. She stated that she is aware of the environmental concerns. She stated that the facility has not had any maintenance personnel until the last 2 months. She stated corporate people come to the facility to assist with things as well the maintenance director. In the fall of 2025, they had a leak that caused a lot of the water damage to ceiling above the nurses' stations. The leak was fixed, but they just need to work on the cosmetic issues.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations, interviews, and record reviews, the facility failed to ensure a resident received appropriate care and services for 1 out of 19 residents reviewed. (Resident #23) The findings include: A record review was conducted for Resident #23 on 3/10/26 at 01:00 pm. Resident #23 was admitted to the facility on [DATE]. Current physician orders revealed that compression stockings were to be worn on bilateral lower extremities before getting up out of bed and were to be removed when back in bed every day for edema. Upon review of the medication and treatment records, compression stockings are documented as being completed. An additional physician's note dated 1/26/26 revealed orders from the vascular physician for Resident #23 to wear stronger knee to hip compression stockings. (photographic evidence obtained) On 3/10/26 at 08:30 AM, an observation was conducted for Resident #23, who was awake and alert, sitting in his wheelchair, but no compression stockings were noted on the bilateral lower extremities. At 12:30 pm, Resident #23 was once again observed in his wheelchair without compression stockings on. Additional observations conducted on 3/11/26 at 8:45 am and 1:09 pm revealed Resident #23 not wearing his ordered compression stockings. An interview was conducted with Nurse D on 3/10/26 at 04:30 pm. She stated that Resident #23 refuses to wear his compression stockings at times. She admitted she checked it was completed on the medication record by mistake. An interview was conducted with Resident #23 on 3/11/26 at 8:45 AM, who stated, I would wear the stockings if the facility had them, but they have not had any for the last several weeks. An interview with the Central Supply Staff person was conducted on 3/11/26 at 11:30 AM. She states that the nurses told her a couple weeks ago that Resident #23 needed new compression stockings; however, he wears a size 3 extra-large and they do not keep that size in stock. She stated they have ordered the size he needs, but they will not be in until Friday. The Central Supply staff confirmed that the facility has been out of the size needed for Resident #23 to wear for the last two weeks.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and policy review. the facility failed to ensure the ice machine was cleaned and maintained in safe operating condition for 1 of 1 ice machines in facility. The findings include: On 3/9/26 at approximately 11:38 AM, the initial kitchen tour revealed an aged ice machine with speckled reddish-brown areas on the outside. [NAME] discoloration covered the strip of paneling above the black lid along the entire border. Black and brown substances covered the top and the seams of the upper unit inside the actual ice storage compartment. [NAME] discoloration extended downward intermittently along the walls. Water leaked from under the machine and pooled on the tiles underneath. On 3/09/2026 at approximately 1:06 PM, an interview was performed with the Regional Certified Dietary Manager (CDM). She acknowledged the discolorations and agreed the ice storage needed cleaning. On 3/10/26 at approximately 3:15 PM, a follow-up observation was conducted on the ice machine. Staff had significantly reduced the black and brown stains. Some black substance still appeared along the ceiling and seams inside the ice storage compartment. The CDM stated that staining caused the remaining black substance to resist removal during the cleaning.		