

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2026
NAME OF PROVIDER OR SUPPLIER Bayside Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4343 Langley Avenue Pensacola, FL 32504	
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 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** Based on observation and interview, the facility failed to maintain a safe functional, sanitary, and comfortable environment when multiple resident rooms, and resident-use areas were observed damaged, deteriorated, unsecured, or unsanitary conditions in 8 of 64 rooms observed. (Rooms 210, 214, 216, 101, 226, 221, 207, and 211) The findings include: 1. On 8/4/26 at approximately 9:30 AM, an observation of room [ROOM NUMBER] revealed the front panel of a drawer on the built-in wall cabinet was broken and hanging downward. Observation also revealed the wall behind the bed was scuffed, with areas of chipped and scraped paint. 2. On 8/4/26 at approximately 9:45 AM, observation of room [ROOM NUMBER] revealed the air return vent grill was rusted and a section of the trim adjacent to the grille was not secured. Rust was observed on the bedframe. Observation of the bathroom floor revealed a broken tile. 3. On 8/4/26 at approximately 10:15 AM, observation of room [ROOM NUMBER] revealed the wall behind the bed was scuffed, with chipped and scraped paint and the wall trim/chair rail behind the bed was missing, leaving an unfinished area of the wall. 4. On 08/03/2026 at approximately 1:00 PM, an environmental observation of room [ROOM NUMBER] revealed a gallon of Clorox in the bathroom. The metal air conditioning shelf was noted to have visible rust. 5. During the observation on 8/6/26 at approximately 10:00 AM, room [ROOM NUMBER]'s dresser was scratched, heavily exposing the wood underneath the paint. 6. On 08/06/26 at 10:10 AM, an observation of room [ROOM NUMBER] revealed the wall behind the bed was scuffed. 7. On 8/6/26 at approximately 10:15 AM, an observation of room [ROOM NUMBER] revealed the wall behind the bed was scuffed, with chipped and scraped paint and the wall trim/chair rail behind the bed was missing, leaving an exposed torn sheetrock to an unfinished area of the wall. 8. On 8/6/26 at approximately 10:18 AM, an observation of room [ROOM NUMBER] revealed the wall behind the bed was scuffed, with chipped and scraped paint, the wall trim/chair rail behind the bed (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was missing, leaving a exposed torn sheetrock to an unfinished area of the wall. Also, the area underneath the window had chipped and scraped paint. On 8/6/26 at approximately 10:00 AM, an interview and walkthrough was conducted with the Maintenance Director. During the walkthrough, the Maintenance Director acknowledged the identified environmental conditions requiring repair or correction. (Photographic Evidence obtained of all above issues)		

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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 and interviews, the facility failed to ensure medications were appropriately stored and inaccessible to residents for 1 of 27 residents reviewed. (Resident #85)The findings include: On 8/3/2026 at 1:00 pm, during an observation of Resident #85's room, a bottle of Vicks VapoRub was observed. When interviewed, Resident #85 stated that he experiences difficulty breathing at night and uses the Vicks VapoRub to help relieve his symptoms. Upon additional observation, Neosporin ointment was also observed in the room. (Photographic evidence obtained) A review of the orders for Resident #85 revealed no orders allowing for self-administration of medications On 8/4/2026 at 10:00 am, during a follow up observations of Resident #85's room, the Neosporin ointment was still at the bedside. However, the Vicks VapoRub had been removed. Resident #85 stated that he wanted the Vicks VapoRub available at night because it helped him breath better. On 8/4/2026 at 12:07 pm, Staff B, Licensed Practical Nurse, acknowledged that Resident #85 did not have an order allowing self-medication but the facility was attempting to obtain provider orders so the resident could keep over-the- counter medications at the bedside. Staff B removed the Vicks VapoRub from Resident #85's room. On 8/5/2026 at 10:30 am, during an observation of Resident #85's room, Neosporin ointment remained accessible on the windowsill.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to maintain dry food and disposable food supplies in the kitchen storage room in a clean, dry, and sanitary environment. On 08/06/26 at approximately 12:45 PM, a tour of the kitchen dry food storage room entrance area revealed an unknown black substance in the ceiling tiles and on the wall behind the door, with an unknown orange substance on the metal ceiling grid. Water was observed dripping from the ceiling. At 12:57 PM, while exiting the kitchen dry food storage, another area of water dripping from the ceiling was observed. An approximately 3x3 section of white plywood screwed into the ceiling was discolored with water pooling and dripping from the ceiling. On 08/06/26 at approximately 12:57 PM, an interview with the Dietary Manager regarding the dry food storage area revealed that they are always mopping in this area. On 08/06/26 at approximately 1:00 PM, an observation of two dry food storage areas outside behind the facility were conducted. The smaller storage area shed front doors were broken at the bottom of the door, leaving an approximately 2-inch gap exposing water bottles, water bladders, and disposable styrofoam boxes to weather and pests. The large storage shed has two sets of doors, with one set of barn wood doors with a crack approximately 12 inches long in height, exposing the contents to weather, rodents, or other pests. The back of this shed's ceiling has an area that was wet and was dark with an unknown black substance. Water was observed dripping from the area onto kitchen equipment, food trays, cases of bottled water, heat lamp and sealed disposable Styrofoam food bowls. On 08/06/26 at approximately 1:10 PM, an interview with the Dietary Manager was performed concerning these concerns. The manager was not aware of these issues but confirmed the ceiling is leaking with an unknown black substance, doors were broken, and a box of styrofoam bowls that were in a plastic bag were wet.		

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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 ensure infection control standards were maintained for vascular access devices in 1 of 1 residents reviewed. (Resident #68) The findings include: On 08/03/2026 at 11:45 AM, an observation of Resident #68 was completed. Resident #68 had a transparent dressing over the midline intravenous catheter in the upper right arm. The dressing was not dated, the edges on two sides of the transparent dressing were loosened and rolling inward and no longer in contact with the skin. On 08/04/2026 at 09:45 AM, an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the nurses change the dressings on midline intravenous catheters as ordered and are supposed to write the date on the dressing.08/05/2026 at 09:50 AM, an interview was conducted with the regional consultant nurse and interim Director of Nursing (DON). The DON stated the expectation is that dressings placed over intravenous catheters will be dated and initialed by the nurse completing the dressing change and dressings will be changed per order and policy.On 08/05/2026 at 2:45 PM, a review of Resident #68's electronic medical record was completed. The provider entered an order on 07/24/2026 to change the midline catheter dressing weekly on Sundays. An entry in Resident #68's care plan dated 07/24/2026 reads to label dressings as per policy.The policy IV Policies and Procedures Manual, Catheter Insertion and Care (effective on 01/17/2019) reads, Place label on one side of catheter (not over insertion site). Include the date and time of catheter insertion and initials.The Centers for Disease Control (CDC) guidelines for the prevention of intravascular catheter-relation infections recommend changing transparent dressings every seven days or immediately if the dressing becomes damp, loosened, or visibly soiled.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview and policy review, the facility failed to ensure a functioning resident call light system was readily accessible to 2 of 4 sampled residents in a shared bathroom. The call light cord was missing, and the call system could not be activated from the floor, creating the potential for delayed assistance in the event of a fall or other need for staff assistance. (Residents #65 and #70) On 8/4/26 at approximately 9:20 AM an observation of the shared bathroom used by Resident #65 and #70 revealed the resident call light cord was missing from the area adjacent to the toilet. The call light could not be activated from the floor in the event a resident fell and was unable to reach the wall-mounted call light. On 8/4/26 at approximately 10:00 AM, an interview was conducted with Employee E, Certified Nursing Assistant (CNA). Employee E confirmed residents should have access to a call light cord while using the bathroom and stated, I will notify maintenance to repair the cord. On 8/4/26 at approximately 10:30 AM, an interview was conducted with Employee P, Licensed Practical Nurse (LPN). Employee P confirmed there should be a functioning call light in each bathroom for residents to summon staff assistance and stated I will contact maintenance to get a cord placed in the bathroom. On 8/6/26 at approximately 10:00 AM, an interview and walk-through were conducted with the Maintenance Director. The Maintenance Director confirmed there was no call light cord by the toilet in the shared bathroom and stated a replacement cord was required. The Maintenance Director stated staff are expected to submit maintenance requests through TELLS, the facility's electronic maintenance/work-order system, when repairs are needed. The Maintenance Director stated he had not been notified of the missing call light cord prior to staff just now bringing the concern to his attention. The call light cord remained unavailable at the time of the 8/6/26 observation. (Photographic Evidence Obtained)		