

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: 105747	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Rosewood Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3107 North H Street 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, staff interviews, record review, and policy review, the facility failed to ensure the interdisciplinary team assessed and determined residents were capable of self-administration of medications prior to allowing 1 of 1 sampled resident to self-administer medications. (Resident # 82) The findings include: On 12/08/2025 at 11:26 AM, an observation of Resident #82 was conducted. He was in bed and was non-verbal. He had several medications inside a large plastic cup on his overhead table within reach. (Photographic evidence obtained) The resident was asked if those were his medications and he placed his left thumb up, indicating that they were his medications. On 12/08/2025 at 11:37 AM, an interview was conducted with Staff A, Licensed Practical Nurse (LPN), who was the current charge nurse. She was asked if Resident # 82 was able to self-administer medications. Staff A, LPN stated Resident #82 was not able to self-administer his medications. Staff A was made aware that the resident had medications inside a cup at his bedside with no staff present. Staff A stated that the nurse that distributed medications should have ensured the medications were taken or disposed them appropriately if refused. A review of Resident #82's electronic medical record was conducted. The record revealed physician's orders to administer medications in the morning that included Gabapentin 600 mg for neuropathy, Lasix 20 mg for edema, Acidophilus 200 mg for probiotic, Clopidogrel Bisulfate 75 mg for apraxia, Tamsulosin 0.4 mg for benign prostatic hyperplasia, Linzess 8 mcg capsule twice daily for constipation, and Calcium 600 tablet daily for low calcium. A review of the quarterly minimum data set (MDS), with an assessment reference date of 11/14/25, was conducted. The MDS revealed that Resident #82 had a brief interview for mental status (BIMS) review, indicating short-term and long-term memory problems and that he was not cognitively intact. Resident #82's medical record was further reviewed and did not contain an assessment or a care plan to self-administer medications. On 12/10/2025 at 8:32 AM, an interview was conducted with Staff B, LPN. She stated she was passing medications on the hallway where Resident #82 resided. She was asked about the process of medication administration. She stated she watched the residents swallow the medications because they could choke. She further stated if residents refused to take the medications, she would chart as refusals on the medication administration record. Staff B reviewed the photographic evidence of the medications left at bedside on 12/8/25 and compared them with Resident #82's scheduled morning medications. She identified the Tamsulosin 0.4 mg capsule and Linzess 8 mcg capsule. On 12/10/2025 8:54 AM, an interview was conducted with Director of Nursing (DON). She stated she was aware that Resident #82 often spits his medications out in a cup. The facility obtained an order to crush medications and also obtained a speech therapy consult. The DON further stated that the nurse that administered the medications should have gone back and take the pills and follow up with documentation. A review of the facility policy Self-Administration of Medication dated October 2019 was conducted. Facility policy stated, The purpose of this procedure is to establish uniform guidelines concerning the self- administration of drugs. General Guidelines A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician and approved by the Interdisciplinary Care Plan Team.		

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 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, staff interviews, and record review, the facility failed to implement appropriate infection control procedures during incontinence care for 1 of 1 resident on isolation Transmission Based Precautions. (Resident #81)The findings include: On 12/11/25 at 9:24 AM, Staff C, a Certified Nursing Assistant (CNA), was observed providing incontinence care, including peri-care and a brief change, to Resident #81. After completing care, the staff disposed of his gloves and gown in the trash bag located in the room, then proceeded to exit the room without hand washing or using hand sanitizer. Staff C used the hand sanitizer dispenser located outside the door. On 12/11/25 at 10:04AM, during an interview with Staff C, he acknowledged that he did not perform proper handwashing before leaving the room. On 12/11/25 at 10:10AM, during an interview with the Director of Nursing, she stated that staff, after removing their personal protective equipment inside the resident room, are to perform handwashing before exiting the resident room. On 12/11/25 at 10:30AM, record review of the facility's Isolation Precautions policy revealed that staff are to remove the gloves before leaving the room and wash hands or use hand sanitizer before leaving the room.		