

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: 105751	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Specialty Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6984 Pine Forest Road Pensacola, FL 32526	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record reviews, the facility failed to develop and implement a comprehensive-person centered care plan for the safety and use of oxygen therapy for 1 of 1 residents sampled for oxygen use. (Resident #39)The findings include:Resident #39 was observed wearing oxygen via nasal cannula with the flow of 1 liter per minute (lpm) on the following dates and times: 9/29/25 at 12:20 PM, 9/30/25 at 9:40 AM, 9/30/25 at 12:15 AM, 10/01/25 at 9:30 AM, and 10/01/25 at 2:00 PM.An interview was conducted with Nurse C, a Licensed Practical Nurse (LPN), on 9/30/25 at approximately 9:45 on 9/30/25. Nurse C indicated Resident #39 has received oxygen via nasal cannula since she was admitted on [DATE].An interview with Nurse D, another LPN, on 10/1/25 at approximately 11:50 AM. Nurse D confirmed Resident #39 wears oxygen continuously at 2 lpm.A review of Resident #39's medical record revealed an active diagnosis of Dependence on Supplemental Oxygen with an active order for oxygen at 2 lpm every shift for Shortness of Breath. A record review of Resident #39's medication administration record revealed the order for oxygen at 2 LPM every shift with nurse initials each shift since admission of 8/13/25. Record review of Resident #39's care plan dated 8/15/25 revealed no care plan for oxygen.An interview was conducted on 10/2/25 at approximately 10:30 AM with the Minimum Data Set (MDS) Coordinator, who also is the Care Plan Coordinator for short term residents. The MDS/Care Plan Coordinator confirmed oxygen was captured on the MDS report dated 8/20/25, but was not captured on the admission care plan dated 8/15/25. The MDS/Care Plan Coordinator stated if oxygen is captured on the MDS, then it should absolutely be captured on the resident's care plan.The facility's policy on care plan states, The care planning and interdisciplinary team (IDT) shall meet as necessary to assure the residents care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs as defined on the resident's assessment.		

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on observations, interviews, and record review, the facility failed to provide adequate monitoring of labs for 1 of 5 residents sampled for unnecessary drugs. (Resident #3) The findings include: Resident #3's medical record revealed an active diagnosis of cirrhosis of the liver and ascites. The medical record revealed the active medications for diagnosis of cirrhosis of the liver and ascites are the following: 1. Xifaxan Tablet 550 Milligram- Give one tablet by mouth two times a day related to Unspecified Cirrhosis of the liver. 2. Ursodiol Capsule 300 Milligram- Give one capsule by mouth one time a day for Biliary Cirrhosis. 3. Lactulose Oral Solution 20 Grams per 30 Milliliters- Give 45 milliliters by mouth four times a day for Hyperammonemia related to Unspecified Cirrhosis of the Liver and Ascites. Resident #3's care plan initiated on 9/7/22 revealed that the resident has the potential for changes in mental status due to history of an elevated ammonia level. The plan states the laboratory values will be monitored for the resident through the next review. The facility is to obtain labs as ordered by the physician to assess baseline lab values and follow up to determine changes in condition. A review of Resident 3's orders revealed the following order: obtain ammonia level on 3/2/25. At this time, the result was 185 and the resident was sent to the emergency room for altered mental status and elevated ammonia level. The next ammonia level order was to be repeated on 3/3/25. The lab reported no specimen was received from the facility. The next ammonia level order was on 5/22/25 with the lab reporting uncollected specimen with no results. Another ammonia level was ordered on 5/23/25 and to be obtained every six months in January and July. The lab reported the facility cancelled the lab order on 7/11/25. No ammonia level was obtained for the July order. The ammonia level was ordered for 10/1/25 but was rejected by the lab due to the bag the sample being damaged in transit. The physician ordered the next ammonia level on 10/1/25 to be repeated on 10/2/25. The lab reported the result of the ammonia level of 43 to the facility. An interview was conducted with Nurse D, a Licensed Practical Nurse (LPN) on 10/1/25, at approximately 2:15 PM. Nurse D described the process of taking lab orders, scheduling them with the lab, and the process of reporting lab results. The nurses take the verbal telephone order or written order from the physician. The order is then added to the resident's chart and in the lab portal with the date and time to obtain the sample. The lab report comes in by computer and the nurses check the lab portal according to who had samples taken for the day. The results are then called to the physician for any new orders. An interview was conducted with the Director of Nursing (DON) on 10/2/25 at approximately 10:25 AM. The DON indicated that the physician calls with the lab orders and nurses on the floor put orders in the resident chart and into the lab portal for the lab company to be notified of when and which resident to get samples. The samples are obtained Monday through Friday between 3:00 am - 5:00 am by the phlebotomist. If the lab is ordered as stat, then the nurse working at that time obtains the sample and sends the sample. The lab portal is checked multiple times a day for lab results. The lab book at the nurses' station has a list of residents with the lab samples they need and the date the sample needs to be obtained. The phlebotomist signs the lab book by the resident's name after the sample is obtained. The staff views the lab book while working their shift to know which resident to look up results in the lab portal. The nurse manager or floor nurse calls the resident's provider with the lab results and obtains any new orders as needed. The physician will look in the lab portal when they are here and verify lab results also. If the lab is rejected, the portal alerts the nursing staff, who will notify the provider for any new orders. Review of the physician's progress note dated 9/22/25 revealed they will reorder ammonia levels, due to the last collection was rejected. An interview was conducted with the physician on 10/1/25 at approximately 3:30 PM. They reviewed the resident's record and confirmed they had intended to order a repeat the Ammonia Level on 10/1/25 and failed to order it.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure that the call system was adequate to allow residents to call for staff assistance through a communication system in 1 of 16 sampled resident rooms (room [ROOM NUMBER]-1) and 2 of 16 sampled resident restrooms (room [ROOM NUMBER] and 347). The findings include: An observation and test of the resident room call system in room [ROOM NUMBER]-1 was conducted on 9/29/25 at 2:48 PM with Employee G (Certified Nursing Assistant). The call system for 302-1 did not appear functional. Employee G acknowledged it was not functional. An observation of the restroom call system cord for room [ROOM NUMBER] was conducted on 9/29/25 at 3:08 PM. The call system cord was observed to be too short to reach the toilet. The cord was only 5 inches long. An observation of the restroom call system cord for room [ROOM NUMBER] was conducted on 9/30/25 at 10:08 AM. The call system cord was wrapped around the toilet seat riser frame and thus did not reach to the toilet. An interview was conducted with Employee A (Certified Nursing Assistant) on 10/2/25 at 8:50 AM. Employee A stated the resident who occupied room [ROOM NUMBER]'s bed 2 usually toileted independently and would at times use the restroom call system. An interview was conducted with Employee B (Certified Nursing Assistant) on 10/2/25 at 9:38 AM. Employee B stated the resident in room [ROOM NUMBER]'s bed 2 toileted himself. The call system cord in room [ROOM NUMBER] restroom was observed in the presence of the Regional Maintenance Director on 10/2/25 at 9:03 AM. He confirmed the call system cord was too short and about 5 inches long. He stated the resident would not be able to reach the call system cord if the resident was in the floor. (Photographic evidence obtained.) The call system cord in room [ROOM NUMBER] restroom was observed on 10/2/25 at 9:32 AM in the presence of the Regional Maintenance Director. He observed the cord and confirmed it was wrapped around the toilet seat riser frame. (Photographic evidence obtained.)		