

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER Pensacola Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 235 West Airport Blvd Pensacola, FL 32505	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observations, interviews, record reviews, policy review, and a review of the Resident Council minutes, the facility failed to uphold resident rights and dignity by not knocking and announcing staff presence before entering the rooms of two residents (Resident #23 and Resident #37). The findings include: On 04/07/2026 at 12:35 PM during observation and interview with Resident #23, Staff P, Certified Nursing Assistant entered Resident #23's room and passed the partially pulled privacy curtain by Resident #23's bed and turned and walked back out of the room. Staff P re-entered the room within a few seconds and knocked on the door and entered stating I have your lunch.</p> <p>On 04/07/2026 at 9:50 AM, at the suggestion of Resident #23, a telephone interview was performed with the local Long Tem Care Ombudsman. The Ombudsman revealed she visited Resident #23 last week and observed three occurrences of staff members coming into Resident #23's room without knocking or announcing themselves. The Ombudsman stated this was a concern for Resident #23, so she informed the facility's Administrator.</p> <p>On 04/07/2026 at 2:55 PM, an interview with the Administrator was conducted. When the Administrator was informed of Staff P entering Resident #23's room without knocking, the Administrator stated he was aware of the Ombudsman reporting issues of staff members entering Resident #23's room without knocking.</p> <p>On 04/06/2026 at 02:28 PM, during an observation and interview with Resident #37, Staff V, Maintenance Personnel entered Resident #37's room without knocking or announcing himself or what he was there to do. Staff V walked directly over to the window to the air conditioning (AC) unit and began taking the unit out from the wall. After removing the front cover of the AC unit, he left the room and entered back into the room after about 5 minutes without stating his purpose or announcing or knocking on the door.</p> <p>An interview with the Director of Nursing was conducted on 04/06/2026 at 3:30 PM. She stated her expectations of all staff is to knock on a resident's door and announce entry into a resident's room and to always explain what they are there for and explain any procedures to a resident prior to initiating care or any services. Requested policy for Resident privacy. (Policy was not provided by facility per request x 2 to DON).</p> <p>An interview with Staff V was conducted at 12:20 PM on 04/07/2026. He revealed he had been employed with the facility for 2 years working in the maintenance department. He stated, I had to change out the AC unit in the room due to leaking onto the floor where the AC was turned down too low. Upon asking him to explain his process for entering a resident's room to perform job duties, he stated, I already know. I didn't knock on the door; I just came right on in and went to work on the AC unit. I have gotten too comfortable with the residents here. He expressed understanding that knocking (continued on next page)</p>

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	respects their privacy and upon asking him how he would feel if someone entered his home or personal space without knocking or announcing themselves before entry, he stated, I would be very upset about it, very, very upset. I will admit I am guilty of doing that, and I cannot promise that it will not happen again, but I will try and do better.		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interviews and record reviews, the facility failed to provide treatment and services to 1 of 1 residents reviewed for pressure ulcers. (Resident #125) The findings include:A record review was conducted for Resident #125. Resident #125 was admitted to the facility on [DATE] with diagnoses including Sepsis due to EColi, Peripheral vascular disease, acquired absence of foot, and wound to right hip. Physician orders included Wound care to cleanse the right great toe with wound cleanser, paint with betadine every day shift (start date 3/13/26); Sacrum, cleanse with wound cleanser, apply barrier ointment and nystatin powder to wound bed every day shift (start date of 3/13/26); Wound Vac -apply wound care vac to right hip at 125mmhg. Cleanse area with normal saline, pat dry, apply wound vac 3 times a week and prn. every day shift on Monday, Wednesday, and Friday to right hip (start date of 3/11/26); Apply skin prep to bilateral heels as tolerated every shift for 14 days (start date of 3/7/26). A plan of care was initiated on 3/10/26 for Resident #125 which stated she had a pressure ulcer to hip with a goal that wound will show signs of healing as evidenced by decrease in size, improved appearance, and be free from infections. A wound care nursing evaluation was completed on 3/10/26 revealing a wound care assessment for a surgical wound to the Right trochanter hip wound that measured 6cm x 2cm x 1cm which was identified on 3/10/26. Wound vac orders were in place, treatment initiated on 3/10/26. A wound care evaluation dated 3/12/26 revealed: right great toe wound that measured 2cm x 1.9cm x 0.1cm which was identified on 3/12/26, wound color black, date treatment ordered 3/12/26.An interview was conducted with Staff X, Wound Care Nurse on 4/9/26 at 9:00 AM. Staff X revealed Resident #125 had a wound vac at home with home health services providing care. Resident #125 went to the hospital then was admitted to facility on 3/7/26 (which was a Saturday). Staff X completed a wound assessment on 3/10/26 and initiated the wound vac to Resident #125's right hip. Staff X confirmed it was a surgical wound, but the wound care physician who came to the facility every week did not address surgical wounds. Upon asking Staff X if she was aware that the wound was a pressure area to the right hip and that it was surgically debrided while at the hospital, she stated she was not aware. When asked to explain why the wound vac did not get placed on Resident #125 on admission, she stated that she didn't work weekends, so no one else at the facility would have been able to place the wound vac. She stated she saw Resident #125 when she returned to work on 3/10/26 (which was a Tuesday) and that's when she initiated the wound vac for Resident #125. An interview was conducted with the facility's Admissions Coordinator on 4/9/26 at 9:35 AM. She stated that any equipment usually is delivered to the facility within 24 hours of being ordered. She stated she ordered the wound vac on 3/4/26 and it was present in the facility prior to Resident 125 being admitted on [DATE]. A copy of the requisition order was made available and indicates a wound vac order was placed on 3/4/26 along with wound vac supplies. An interview was conducted with the facility's Director of Nursing (DON) on 4/9/26 at 10:19 AM. The DON revealed that facility's staff nurses are all knowledgeable in applying wound vacs as well as the wound care nurse. The DON stated it was her expectation that, if the wound vac was present and the nurses were aware of the need for a wound vac to be administered to a resident, then it should be completed the day the resident is admitted to facility. She confirmed the wound vac should have been placed on Resident #125 the day she was admitted -on 3/7/26.</p>		