

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/25/2026
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)		
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, review of the facility's policy and education, and review of Florida Administrative Code, the facility failed to ensure that residents who required ileostomy services received such care consistent with professional standards of nursing practice for 2 of 2 residents reviewed for ileostomy care (Resident #1 and #2). The findings included: On 06/24/2025 at approximately 8:30 AM, an initial tour of the facility was conducted. Resident #1 and Resident #2 were identified as having ileostomies (a surgical procedure that diverts digestive waste out of the body by connecting the lowest part of the small intestine (the ileum) to an opening in the abdominal wall, by passing the colon). A review of Resident #1 medical record revealed he was first admitted to the facility on [DATE]. His medical history was significant for an ileostomy. Resident #1 had multiple hospitalizations and was last readmitted to the facility on [DATE]. Review of his Minimum Data Set (MDS) revealed Resident #1 had a Brief Interview of Mental Status (MDS) score of 6, which indicates he had significant cognitive impairment and was therefore not appropriate for interview. Review of Resident #1's physician orders revealed an order was written for Ostomy care Q (every) Shift with a start date of 04/30/2026. This order was discontinued on 05/13/2026 (photographic evidence obtained). When Resident #1 was re-admitted on [DATE], no orders were written for ostomy care (photographic evidence obtained). Review of Resident #1's Plan of Care revealed there was a care plan regarding the presence of Resident #1's ileostomy with a goal written for patency and function of the stoma. Interventions included skin barrier around the stoma to protect from excoriation secondary to urine feces, monitor and report for abnormal bleeding in collection bag or continuous bleeding from stoma and/or surrounding skin as a CNA task, and monitor and report to provider if skin around stoma shows increased irritation, ostomy care daily and as needed as nursing task (photographic evidence obtained). Review of the nurse documentation specified the nurse signed off on 06/01/2026 and 06/03/2026 documenting they changed the ileostomy related to a fistula/abscess that was located directly next to the ileostomy. Further review revealed the CNAs colostomy task completed was signed off by CNAs. However, this documentation did not specify change wafer. On 06/24/2026 at approximately 9:40 AM, an interview was conducted with Resident #2. Resident #2 reported having an ileostomy for more than 10 years. He reported that over the past 2 weeks he had used approximately 8 ostomy wafers because they leaked stool due to incorrect wafer size and improper application. Resident #2 further stated that, unlike previous facilities where the nurses performed his ostomy care, Certified Nursing Assistants (CNA) at this facility routinely performed the ostomy care, including the ostomy wafer application. He stated the leakage occurred because the staff were not using the appropriate template to cut the wafer opening, often cutting it too large. He expressed further concern of the staff not allowing his skin to fully dry before applying the wafer to his skin. He expressed concern that most of the facility's CNAs did not appear to be competent or adequately trained to perform the task of ostomy care. A review of Resident #2's medical record revealed Resident #2 was admitted to the facility on [DATE]. Review of his MDS revealed he had a BIMS score of 15, which indicates he was cognitively intact. Review of Resident #2's physician orders revealed an order was written on 04/17/2026 for Ostomy site: monitor stoma and surrounding skin for any abnormalities, (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify provider if indicated (photographic evidence obtained).On 06/24/2026 at approximately 10:42 AM, an interview was conducted with Staff C, Licensed Practical Nurse (LPN), Unit Manager. Staff C explained that both nurses and CNAs were trained to provide ostomy care, as CNAs were permitted to perform it within their scope of practice.On 06/24/2026 at approximately 11:35 AM, an interview was conducted with Staff D, Registered Nurse (RN) and Unit Manager. Staff D stated he had knowledge of towels being used to manage the stool leakage for Resident #1's ostomy on one to two occasions. He explained the stool leakage occurred because the wafer opening had been cut too large. He further stated some staff were unfamiliar with the proper ostomy care, particularly how to correctly cut the wafer. He stated that there were no physician's orders for ostomy care as it was a CNA task and was documented as such.On 06/25/2026 at approximately 12:44 PM an interview was conducted with Staff E, Advanced Registered Nurse Practitioner (ARNP). She stated that ostomy care orders were generated as part of the facilities standard order set. She further stated she did not personally enter those orders. She confirmed that it was appropriate and expected to have an ostomy care order present in a resident's medical record.On 06/24/2026 at approximately 2:45 PM, an interview was conducted with the Director of Nursing (DON). He confirmed that Resident #1 did not have any monitoring orders for ostomy care since his last readmission on [DATE], as the facility did not initiate ostomy orders. When asked how the facility monitored an ostomy site, he stated that it was only a CNA task initiated and the CNAs were the only ones that would document on the medical record that care was provided. He explained that CNAs could perform ostomy care including changing the wafer if they were comfortable with the task; otherwise, the nurses would provide the care. He stated that all staff received refresher education and the competency checklist validation was completed during onboarding (Photographic evidence obtained). Staff were expected to ensure that the ostomy bag was applied correctly and appropriately size the wafer opening to prevent leakage. When asked how the facility monitored for complications related to an ostomy, he stated that care is provided since it is documented in the CNAs tasks. He added that if the CNAs had any concerns they would report to the nurse. The DON independently reviewed Resident #1's physician orders and confirmed that an order was in place for the ostomy care prior to the last readmission on [DATE] but had been discontinued (Photographic evidence obtained).On 06/24/2026 at approximately 3:38 PM, an interview was conducted with Staff G, CNA. She explained although CNAs were permitted to provide ostomy care with wafer change, she chose to just empty the bag. She stated that documenting ostomy care on the CNAs task on the electronic health record, referred to emptying the bag, not changing the wafer or bag.On 06/25/2026 at approximately 8:11 AM, an interview was conducted with Staff J, CNA. She explained that both nurses and CNAs could complete ostomy care that consisted of changing all the ostomy supplies, including the wafer. She stated that she attempted to perform the task but experienced leakage each time, resulting in a mess. As a result, she chose to leave the ostomy care to the nurses and just emptied the bag.On 06/25/2026 at approximately 8:15 AM, an interview was conducted with Staff K, CNA. She explained that she provided ostomy care to residents by emptying the ostomy bag and changing the wafer if needed.On 06/25/2026 at approximately 9:21 AM, an interview was conducted with the Administrator. He recalled Staff D had reporting that Resident #1 was having difficulty with ostomy leakage. He explained that both nurses and CNAs performed ostomy care, including changing the wafer. He stated he was unaware that this task may not be permitted under the license or scope of practice of a CNA.On 06/25/2026 at approximately 11:55 AM, an interview was conducted with the Assistant Director of Nursing (ADON). She stated that she was unaware that ostomy care that included changing the wafer, was out of the scope of practice under a CNA's license.A review of the facility Colostomy Skills Competency for CNAs was reviewed. It included assessing the skin around the stoma for irritation, measuring the stoma using a sizing template, cutting the opening, and applying the ring (Photographic evidence obtained).A review of the facility Ostomy Care refresher conducted on 06/03/2026-06/05/2026 by the ADON for all nursing and certified nursing assistants was reviewed. Ostomy care included cutting the supply to fit the stoma (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opening. (Photographic evidence obtained).Facility policy titled Colostomy Care issued 06/2020 and last revised 11/2023 was reviewed. It stated that ostomy care will be provided per physician orders. Review the resident care plan to assess any special needs of the resident and assemble the equipment and supplies as needed. The date and time the colostomy/ileostomy care was provided, the name and title of the individual who provided the care, how the resident tolerated the procedure. Notify the supervisor if the resident refuses care, any abnormal findings (i.e. breaks in skin, excoriation, signs of infection, etc.), and any information in accordance with facility policy and professional standards of practice.Per review of the Florida Administrative Code R. 59A-18.0081 for Certified Nursing Assistant and Home Health was reviewed. The certified nursing assistant (CNA): (1) Be limited to assisting a patient in accordance with Section 400.506(6)(b), F.S.(5) Perform other activities as taught and documented by a registered nurse, concerning activities for a specific patient and restricted to the following:(a) Assisting with the placement or removal of a colostomy bag, excluding the removal of the flange or manipulation of the stoma's site.Florida Administrative Code Department of Health Board of Nursing Chapter 64B9-15 - CERTIFIED NURSING ASSISTANTS, Section 64B9-15.002 - Certified Nursing Assistant Authorized Duties further states A certified nursing assistant shall provide care and assist residents with the following tasks related to the activities of daily living under the general supervision of a registered nurse or licensed practical nurse. (d) Tasks associated with elimination. 5. Emptying ostomy bags, or changing bags that do not adhere to the skin.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to follow acceptable nationally accepted infection prevention and control standards including proper use of Personal Protective Equipment (PPE) to prevent the spread of infections for 2 of 2 residents observed for direct resident care (Resident #1, #5). The findings included: On 06/24/2026 at approximately 8:42 AM, an observation was made of Resident #1's room. An Enhanced Barrier Precaution (EBP) sign was posted on the outside of the room door. While touring the room, it was noted that multiple used enteral feeding syringes were present in the room in undated bags (Photographic evidence obtained). During this observation, Staff A, Registered Nurse (RN), entered the room and donned gloves. Staff A refilled the empty hydration bag and used one of the open, undated syringes to flush Resident #1's peg tube (a flexible feeding tube which is surgically placed through the abdominal wall directly into the stomach). Staff A then reconnected the tube feeding tubing to Resident #1's feeding tube and restarted the tube feeding pump. It was noted during this observation that Staff A did not wear the appropriate isolation gown while providing this care to Resident #1. A review of Resident #1 medical record revealed he was last readmitted to the facility on [DATE]. His medical history was significant for an ileostomy (a surgical procedure that diverts digestive waste out of the body by connecting the lowest part of the small intestine (the ileum) to an opening in the abdominal wall, by passing the colon) and a peg tube. Review of Resident #1's medical record revealed the order for EBP was initiated on 05/20/2026 related to his peg tube and wounds. The order did not acknowledge that the EBP was also related to Resident #1 having an ileostomy. Additionally, an order initiated on 05/15/2026 revealed Enteral feeding, change feeding set/bag/syringe every night shift. Further review of the medical record revealed a progress note written by the Medical Director, dated 06/16/2026. This note documented that Resident #1 had a medical history significant for an ileostomy and C-Diff (Clostridioides difficile, a highly contagious bacterium that infects the large intestine, causing severe watery diarrhea and colon inflammation). The note further indicated that Resident #1 had a recent hospitalization on 05/08/2026, during which he tested positive for MRSA associated pneumonia (Methicillin-resistant Staphylococcus aureus, a bacterium that has developed resistance to many common antibiotics). Resident #1 was initially treated with two intravenous antibiotics and was then transitioned to two alternate antibiotics for these infections. Review of Resident #1's Plan of Care revealed a care plan was written regarding Resident #1 requiring EBP during high contact resident care activities related to peg tube and wounds. Interventions for this care plan included require protective measures and the importance of adhering to protocols to prevent the spread of infections during high contact care activities. On 06/24/2026 at approximately 8:45 AM, an interview was conducted with Staff A. Staff A stated that wearing an isolation gown under Enhanced Barrier Precautions (EBP) was not necessary when flushing or connecting a peg tube; isolation gown use was required for changing dressings or providing ostomy care. She acknowledged that the enteral feeding syringes were undated and could not determine when they were last used. She confirmed that they should be dated when first opened. On 06/25/2026 at approximately 11:30 AM, an observation was made of Resident #5's room. An Enhanced Barrier Precaution (EBP) sign and a Protective Personal Equipment (PPE) cart were posted on the outside of Resident #5's door (Photographic Evidence obtained). After knocking on the resident's door with the plan to conduct an interview with the resident, Staff L, Certified Nursing Assistant (CNA) opened the door stating, resident care. Staff L, CNA and Staff M, CNA were observed completing a transfer of Resident #5 using a Hoyer lift. Both staff members were observed wearing gloves but were not wearing isolation gowns during the resident care activity. On 06/25/2026 at approximately 11:35 AM, a combined interview was conducted with Staff L and Staff M. They explained that Resident #5 was on EBP because he had a peg tube. They acknowledged the EBP signage and PPE cart located outside the resident's room. They confirmed they did not wear the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required isolation gowns during the resident transfer. They stated they were in a hurry and forgot to put on the isolation gowns before providing care to and transferring Resident #5. On 06/25/2026 at approximately 11:38 AM, an interview was conducted with Resident #5. The resident stated that staff had just finished providing her care and transferred her to her wheelchair using the Hoyer lift. She added that staff did not wear isolation gowns during her care or showers. On 06/25/2026 at approximately 1:00 PM an interview was conducted with the facility's Administrator. He explained that the staff were expected to wear the appropriate PPE while providing care to residents on EBP per facility infection prevention policy. Policy titled EBP issued 03/2024 and last revised 05/28/2024 was reviewed. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of Multi Drug Resistant Organism (MDRO) that employs targeted gown and glove use during high contact resident care activities. EBP Are used for residents with indwelling medical device that includes central lines, urinary catheters, feeding tubes, tracheostomy, ostomies. Appropriate Personal Protective Equipment (PPE) would include gowns and gloves. Employees should wear appropriate PPE when performing the following duties for residents: dressing, bathing and showering, transferring, providing hygiene, changing linens, providing peri-care such as changing briefs, toileting, device care and wound care. Employees are not required to wear PPE when answering a call light, delivering a meal tray, conversing with the resident, administering medications that do not involve high contact with the resident such as oral medications, eye drops, inhalers, nebulizers or injections.		