STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105935	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pensacola Nursing & Rehabilitation Center	235 West Airport Blvd Pensacola, FL 32505

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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. 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. 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. 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. 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). 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)

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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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to inform residents of care and treatment prior to the start of care and treatment of psychotic medication for 2 out 5 residents reviewed for general consent to treat (Resident # 12 and #37).The findings include:A record review was conducted for Resident #12. Resident #12 was readmitted to the facility following a hospital stay on 2/12/26 with the diagnoses including major depressive disorder, anxiety, bipolar disorder, and insomnia. Resident #12's medical record revealed they had a brief interview for mental status score of 15, which meant she was cognitively intact. Review of Resident #12's physician orders revealed that Resident #12 was taking Paroxetine Mesylate daily for depression, Trazodone nightly for insomnia (psychotropic), Topiramate twice a day for bipolar disorder, and Hydroxyzine three times a day for anxiety. A review of Resident #12's Minimum Data Set, dated [DATE] indicated the use of antidepressant medications being used. The care plan, with the review date of 2/26/26, indicated that Resident #12 took antidepressant medication related to depression and had a psychiatric consult. Further review of Resident #12's medical record revealed there was no consent for psychotropic medications present in the chart. An interview was conducted on 4/8/26 at approximately 1:30 PM with the Director of Nursing (DON), requesting the consent for Paroxetine, Trazodone, Topiramate and Hydroxyzine as there was no evidence that informed consent specific to the use of psychotropic medications was obtained prior to administration of the medications. On 4/9/26 at approximately 11:45 PM, the DON supplied a consent dated 5/16/25 that was signed by Resident #12 and a Licensed Practical Nurse. Closer review of this document revealed there were no medications listed on the consent form. A record review was completed for Resident #37. Resident #37 was admitted to the facility on [DATE] with the diagnoses of Polyneuropathy, Lupus, Cellulitis of left lower extremity, heart attack, Anxiety, Pulmonary embolism, and Depression. She was receiving the following medications since admission to facility: Zolpidem for sleep, Xanax for anxiety, and Fluoxetine for depression. Resident #37 had plans of care for Insomnia including use of hypnotic medication for sleep initiated on 4/7/26, depression including use of an anti-depressant medication related to depression disorder initiated on 4/8/2026, and for anxiety including use of anti-anxiety medication due to anxiety disorder with date of 04/06/2026. Review of Resident #37's MDS showed use of antianxiety, antidepressant, and hypnotic medications. Further review of Resident #37's medical record revealed there was no consent for psychotropic medications present in the chart. An interview was conducted with the DON on 4/8/2026 at 5:15 PM. She stated that they were unable to locate the admission documents, including consents to treat, consent for advance directives, and psychotropic medication consents. She further explained that treatment should not have been initiated without consent first.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to maintain required advance directive documentation for 2 of 35 sampled residents (Residents #37 and #114). The findings include: A record review was completed for Resident #37. This review revealed Resident #37 was a full code, but no advance directive education discussion sheet was available in the electronic medical record. Resident #37 had a plan of care, dated 2/10/26, which indicated she requested Full Code status. An interview was conducted with the Director of Nurses (DON) on 4/8/26 at 5:15 PM. She stated, We are unable to locate the admission documents, including [Resident #37's] consent for advance directives. During a record review of Resident #114, the electronic medical record contained no admission consent or advance directive documentation since admission on [DATE]. Requests for these documents were made to the Administrator on 4/7/26 at 10:44 AM and again during an interview with the Social Services Director on 4/7/26 at 12:57 PM. By 3:16 PM on 4/7/26, the facility still could not produce the advance directives documentation to the survey staff. A subsequent request on 4/8/2026 at 12:29 PM also yielded no documentation.

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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, interview, and record review, the facility failed to maintain a clean and comfortable environment for 2 of 29 sampled occupied resident rooms. (Rooms #201 and #206) The findings include: On 4/6/26 at approximately 12:30 PM, during the initial tour, occupied room [ROOM NUMBER]'s shower was observed with black grime on the tile walls and floors. The shower drain was covered with hair and a thick white substance. (Photographic evidence obtained)An interview conducted with room [ROOM NUMBER]'s occupant, who stated he had been using the shower in his room. The resident further stated he had asked the staff multiple times to clean it. On 4/7/26 at approximately 10:30 AM, an additional observation was made. The shower still had black grime on the tile walls and floors. The shower drain was still covered with hair and thick white substance.A follow up interview was conducted with the room's occupant, who stated he wanted to take a shower but wanted it cleaned first.On 4/7/26 at approximately 12:45 PM, an interview conducted with Staff B, Housekeeping, who stated the rooms, bathrooms, and showers get cleaned daily.On 4/7/26 at approximately 12:55 PM, an interview conducted with Staff C, Housekeeping Manager (HM), who stated his expectations were for staff to clean bedrooms, bathrooms, and showers daily and deep cleans are conducted monthly. The HM stated there were logs for the deep cleaning schedule and rooms were assigned per month. A tour was conducted with the HM, who observed room [ROOM NUMBER]'s shower and stated he would not want to use the shower with grime and hair in the drain. The HM went on to state the shower did not look like it had been cleaned. The HM reviewed the monthly deep cleaning schedule, which revealed room [ROOM NUMBER] was not cleaned by the staff.Review of Facility's Deep Clean Verification form for room [ROOM NUMBER] (dated 3/20/26) page 1 of 1 revealed: unsatisfactory for resident bathroom shower sanitized & shower curtain checked. (Photographic evidence obtained.) On 4/6/26 at approximately 9:00 AM, during the initial tour, room [ROOM NUMBER]'s bathroom was observed. An observation of the toilet revealed a thick brown and black substance around the base of toilet. There was also approximately a half inch gap where the toilet was pulled away from the floor. (Photographic evidence obtained) On 4/8/26 at approximately 12:05 PM, a tour was conducted with the Administrator and Maintenance Director. They both observed the base of the toilet with the black substance and that the toilet was pulled away from the floor. An interview was conducted with the Maintenance Director. He stated the staff should report repairs by writing a ticket, calling, or entering in the facility's Secura System. They both stated the toilet would be repaired. A review of Facility's Maintenance Service policy (dated 12/2009) page #1 of 2 revealed: The maintenance department is responsible for maintaining the buildings, ground, and equipment in a safe and operable manner. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. (Photographic evidence obtained.)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based upon interview and record review, the facility failed to follow up on a grievance for 1 of 3 residents reviewed (Resident #40)The findings include: On 04/06/2026 at 12:13pm, an interview with Resident #40's sister was conducted. Resident #40's sister stated clothing items went missing in March and, when she reported it, she was informed a grievance would be completed and the facility would resolve the issue. She stated it had been about three weeks, and she has not heard the resolution.On 04/08/2026 at 2:07pm, an interview with the Social Services Assistant and the Director of Social Work was conducted. A review of the facility grievance logs from 01/28/2026 through 03/31/2026 was also conducted. There were no entries in the grievances logs regarding Resident #40. The Social Services Assistant stated she was not aware of a grievance filed by the sister of Resident #40. There was no grievance log for April 2026. The Social Services Assistant stated she still needs to make the April log. The Director of Social Work stated they could not locate a grievance form regarding Resident #40.On 04/09/2026 at 9:36am, an interview was conducted with the Director of Admissions. She stated Resident #40's sister informed her of missing clothing items, and she completed the grievance form and turned it into the Social Services office. The Director of Admissions stated she did not know the exact date but stated it was not long after Resident #40 was admitted to the facility. She also stated she is unsure of the specific person she handed the grievance form to, but she stated it was one of the two people who work in Social Services. On 04/09/2026 at 11:50am a review of the facility procedure titled, Standards and Guidelines: Grievance - Resident Rights was conducted. The procedure revealed in Step #8, upon receipt of a grievance and/or complaint, the Grievance officer will review and investigate the allegations and submit a report of such findings to the Administrator within five (5) working days and Step #12 reveals, The resident or person filing the grievance and/or complaint on behalf of the resident, will be informed (verbally and/or in writing as per request) of the findings of the investigation and the actions that will be taken to correct any identified problems, and Step 12a., The Administrator, or his or her designee, will make such reports orally within ten (10) working days of the filings of the grievance or complaint with the facility.

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan for 2 of 2 residents sampled for indwelling urinary catheters (Residents #10 and #122) and 1 of 2 residents reviewed for falls (Resident #11).The findings include: On 4/6/26 at approximately 1:14 PM observations were made of the indwelling urinary catheters for Resident #10 and Resident #122. A review of Resident #10's clinical record revealed they were admitted to the facility on [DATE]. Further review revealed Resident #10 had an active physician's order for a Foley catheter. The Comprehensive Care Plan failed to include a care plan focus area for the indwelling urinary catheter or catheter care interventions. Review of Resident #122's clinical record revealed they were admitted to the facility on [DATE]. Further review revealed Resident #122 had an active physician's order for a Foley catheter. The Comprehensive Care Plan failed to include a care plan focus area for the indwelling urinary catheter or catheter care interventions. On 4/8/26 at approximately 1:10 PM, an interview was conducted with the Minimum Data Set (MDS) Coordinator. The MDS Coordinator stated the indwelling urinary catheter care plan for Resident #10 and Resident #122 should have been developed within 48 hours of their admission and admitted that it had been omitted for both residents. Observations were conducted of Resident #11 on 4/6/26 at 11:57 AM, 4/7/26 at 10:02 AM, 12:25 PM, 3:26 PM and 4/8/26 at 9:11 AM. During each of these observations, Resident #11 was seen lying and moving around in their bed. During each of these observations, it was noted that there was no fall mats present at the bedside. A review of Resident #11's physician's orders revealed an active order for fall mats to be placed at the bedside due to Resident #11 having a history of falls. A review of the care plan revealed Resident #11 was identified as being at risk for falls related to weakness and involuntary movements and included the use of fall mats as an intervention. Despite the physician order and care plan interventions, fall mats were not in place for Resident #11. On 4/8/26 at approximately 9:00 AM, an interview with Staff X, Certified Nursing Assistant (CNA) confirmed Resident #11 had not had any fall mats in place since they were moved into their current room. On 4/8/26 at approximately 1:49 PM, an interview with Staff E, Unit Manager (UM) revealed Resident #11 was recently moved to their current room and the fall mats were not transferred with the resident but that they should have been.

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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. Based on observations, interviews, and record reviews, the facility failed to carry out physician orders for 2 of 20 residents reviewed. (Resident #69 and #108)Observations of Resident #69 were conducted on 04/06/2026 at 12:30 PM and 4:30 PM, 04/07/2026 at 11:30 AM, 2:30 PM, and 4:30 PM, 04/08/2026 at 8:38 AM. During each of these observations, it was noted that Resident #69 had contractures to bilateral hands. Closer observation revealed no splints or braces were in place during these observations. A record review revealed a physician order for Splint/Brace application, Encourage and assist resident to participate with donning and doffing of Bilateral palm protectors' splint/brace. Bilateral Palm protectors to be used at all times except for ADLs and skin assessment. Monitor skin surfaces under device and notify physician of abnormal findings This order was initiated on 3/31/2026. Resident #69 also had a plan of care in place for skin impairment to left palm with the goal that she will be free from any skin impairment through review date and skin will show signs of healing without complications initiated on 2/3/26. One goal is to apply palm guard due to debility / weakness, decrease in strength, decreased cognition, presence of contractures initiated on 03/25/2026. The care plan went on to document that Resident #69 is to wear bilateral palm guards during the day, date initiated 05/31/2024, revised 03/24/26. An interview was conducted with the Director of Nursing (DON) on 04/09/2026 at 10:19 AM, who revealed that the restorative nurse was out and the restorative aide only worked every other week. The DON revealed that she was aware the restorative process was broken, and the residents who were on the restorative program were not receiving consistent care to meet their needs. During an interview on 04/06/2026 at 2:45 PM, Resident #108 reported that her incontinence briefs were too small and tight and stated she had been experiencing burning with urination for several days. On 04/06/2026 at 4:12 PM, Staff T, Certified Nursing Assistant (CNA), reported to Staff E, Nurse Manager that Resident #108 continued to complain of burning during urination while Staff T was providing care. A record review for Resident #108 showed that a urinalysis was ordered on 03/31/2026 at 5:00 PM. The record also showed that Resident #108 had a history of urinary tract infections (UTI). The care plan, updated on 02/09/2026, indicated Resident #108 was at risk for UTIs and that labs should be monitored as ordered. During an interview on 04/08/2026 at 2:40 PM, Staff G, Licensed Practical Nurse (LPN), reviewed the outgoing lab binder and confirmed that no laboratory specimens had been sent for Resident #108 since the urinalysis order was written on 03/31/2026. Staff E was notified and stated another order would be entered for a straightˆcatheter urinalysis due to reported resident refusal to provide a sample. However, a review of the resident's record contained no documentation indicating Resident #108 had refused to provide a sample.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record reviews and interviews, the facility failed to monitor weights for 1 of 3 residents reviewed for weights (Resident #9).The findings include:During an interview conducted with Resident #9 on 4/6/26 at approximately 2:06 PM, he stated he had lost some weight since being admitted to the facility.A review of Resident #9's clinical record revealed an active physician's order, dated 2/6/26, for weights 3 times a week every Monday, Wednesday, and Friday. The Comprehensive Care Plan included a care plan focus area for at risk for alteration nutrition/hydration related to history of weight loss/weight fluctuations due to Congestive Heart Failure (a chronic condition where the heart does not pump blood efficiently enough to meet the body's needs) and Edema (swelling caused by excess fluid trapped in the body's tissues) with interventions for weights as ordered. (Photographic evidence obtained.)Review of the facility's list for obtaining regular weights (dated 3/30/26) revealed Resident #9's name was omitted. (Photographic evidence obtained.)On 4/7/26 at approximately 12:30 PM, Staff A, Licensed Practical Nurse (LPN) independently reviewed Resident #9's weight input on the Medication Administration Record and stated Resident #9 did have an active order to obtain weights 3 times a week on Mondays, Wednesdays, and Fridays. Staff A stated she was unaware why the weights were not documented in the computer. On 4/7/26 at approximately 1:15 PM an interview conducted with Staff E, Unit Manager (UM). She stated the restorative aide was responsible for obtaining weights on residents and the assigned nurse would follow up if no weights were obtained. Staff E reviewed the clinical record for Resident #9 and stated she did not know why the weights were not obtained per the physician order.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and record reviews, the facility failed to ensure ongoing communication and collaboration was maintained with the dialysis facility for 1 of 1 resident reviewed for dialysis services (Resident #52).The findings include:On 4/7/26 at 9:31 AM, Resident #52 was out of the facility for dialysis treatment. Resident #52 returned to the facility after lunch, around 2:00 PM. An observation was conducted at 4:15 PM with Resident #52. He voiced being tired due to his treatment but was okay. On 4/8/26 at 11:30 AM, during an interview with Resident #52, he stated, I don't always get the paperwork to take with me to the dialysis center.A record review revealed that Resident #52 was initially admitted to the facility on [DATE] and re-admitted to facility on 8/7/25 post hospitalization with diagnoses including end stage renal disease (ESRD), arteriovenous fistula, and dependence of dialysis. He was ordered for dialysis every Tuesday, Thursday and Saturday for his ESRD. Resident #52 had a plan of care for being at risk for fluid imbalance related to kidney failure, fluid restrictions. Resident #52 was at risk for complications related to hemodialysis with goal that he will be compliant with dialysis appointments, nursing interventions and physician orders.The dialysis communication binder with instruction sheet present in front of binder revealed contains tabs of patients who has dialysis for your unit, dialysis sheets will need to be filled out by our nurse prior to dialysis clinic nurse, and then vital signs once patient arrives at facility, if patient does not have sheet filled out and back to facility, contact the dialysis clinic to retrieve the portion where the dialysis clinic.A review of the Long-term care facility outpatient dialysis services care coordination agreement: section B information sharing: for the purposes of care coordination, in advance of each resident's dialysis treatment, long term care facility shall furnish all information and documentation necessary for dialysis facility to provide safe and appropriate care, including any and all information reasonably requested by dialysis facility. Further review of hemodialysis communication records dated 3/2/24, 2/5/26, and 3/14/26 revealed no documentation of collaboration of care is observed in the medical chart or in dialysis communication binders on the unit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, staff interviews, and record reviews, the facility failed to acquire pain medication from the pharmacy in a timely manner to ensure proper continuity of care for 1 of 1 resident reviewed for pain (Resident #103).The findings include: On 4/6/26 at approximately 12:00 PM, an interview was conducted with Resident #103. Resident #103 stated he received Tramadol twice a day, but did not receive any pain medication on 4/3/26, 4/4/26 or 4/5/26. He further stated he worked out every morning despite not having his pain medication and was not going to let the pain stop him from participating in activities he enjoyed. A review of Resident #103's medical record was conducted. A review of Resident #103's diagnoses include fractured tibia, cervicalgia, and chronic pain. Further review revealed an order for Tramadol 50 mg by mouth every day at 9:00 AM and 11:00 PM. A review of the medication administration record (MAR) for April 2026 confirmed Resident #103 did not receive Tramadol on 4/3/26, 4/4/26, and 4/5/26. The documented reason indicated the medication was not available. On 4/8/26, at approximately 8:30 AM, an interview was conducted with Staff N, Licensed Practical Nurse (LPN). Staff N stated if a medication was empty in the medication cart and not available from the Pyxis machine (an automated medication dispensing system used in healthcare for secure, efficient, and traceable medication management), the nurse should notify the Physician or Advanced Registered Nurse Practitioner (ARNP) for further guidance. On 4/9/26 at approximately 8:25 AM, an interview was conducted with Staff L, LPN. Staff L confirmed that on 4/3/26, the night shift nurse had informed him Resident #103 did not have Tramadol in the medication cart or in the Pyxis machine. He stated he had contacted the ARNP regarding this and she informed him that she was taking care of reordering Resident #103's Tramadol. Staff L, LPN stated the medication never arrived from the pharmacy. He further stated he was not aware he needed to call the pharmacy and if the medication was not available to give to the patient, he should notify the physician or ARNP.On 4/9/26 at approximately 2:00 PM, an interview was conducted with the Director of Nursing (DON). She stated her expectation if a medication is not available in the medication cart or Pyxis, the nurse should contact the pharmacy. If the pharmacy is unable to deliver or complete the order, the nurse should notify the doctor or ARNP for an alternative medication. Review of the facility policy, Standards and Guidelines: Medication Administration, (issued 10/2020 and revised 1/2024) stated, If a Drug is withheld, refuse, or given at a time other than the scheduled time, The individual administering the medication shall document the rationale in the residence medical record and notify the physician. And responsible party if indicated. Medications will be reordered as needed with practitioner approval unless otherwise indicated. (ie auto-refill from pharmacy, emergency medication supply use, etc)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105935	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pensacola Nursing & Rehabilitation Center	235 West Airport Blvd Pensacola, FL 32505

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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 ensure appropriate infection control practices were followed for 3 of 3 residents reviewed for infection control (Residents #1, #10, #122). The findings include:On 4/6/26 at 1:50 PM, an observation was made of Resident #1 eating lunch. During this observation, it was noted that red biohazard bags were on the floor of Resident #1's room. An interview was conducted at the time of the observation with Staff J, Certified Nursing Assistant. Staff J stated that Resident #1 did not have a roommate because Resident #1 was on Transmission Based Precautions (TBP) for Methicillinˆresistant Staphylococcus aureus (MRSA) in a wound (MRSA is a drug-resistant bacteria). It was noted that no TBP signage was posted on the door of Resident #1's room. An additional observation of Resident #1's room was conducted on 4/7/26 revealed that no TBP sign was present. A review of the medical record showed that TBP had been ordered on 4/6/26. On 4/8/26, it was observed that an Enhanced Barrier Precaution (EBP) sign was posted on the outside of Resident #1's room. On 4/8/26, an interview with the Director of Nursing was performed. She acknowledged these signs had not been present until that day. On 4/6/26 at approximately 1:14 PM, observations were made of indwelling urinary catheters for Resident #10 and Resident #122. During these observations, it was noted that there was no signage posted for Enhanced Barrier Precautions (an infection control measure requiring staff to wear gowns and gloves during high-contact care) on the doors of either resident. A review of Resident #10's clinical record, admitted [DATE], revealed an active physician's order for Enhanced Barrier Precautions. The Comprehensive Care Plan, reviewed on 4/7/26, included a care plan focus area for Enhanced Barrier Precautions with interventions. (Photographic evidence obtained.) Review of Resident #122's clinical record, admitted [DATE], revealed an active physician's order for Enhanced Barrier Precautions. The Comprehensive Care Plan, reviewed on 4/7/26, included a care plan focus area for Enhanced Barrier Precautions with interventions. (Photographic evidence obtained.) On 4/7/26 at approximately 9:00 AM a follow up observation was conducted with Staff A, Licensed Practical Nurse (LPN), who acknowledged signage for Enhanced Barrier Precautions needed to be posted for Resident #10 and Resident #122. Staff A stated a sign would be posted. On 4/7/26 at approximately 12:55 PM, an interview was conducted with Staff E, Unit Manager (UM). Staff E confirmed that an Enhanced Barrier Precautions sign should have been placed on the door of the resident's rooms for the staff to know what Personal Protective Equipment (PPE) to wear. On 4/7/26 at approximately 1:30 PM, an interview was conducted with Staff F, Certified Nursing Assistant (CNA). Staff F stated she was unaware of what appropriate PPE to wear for Resident's #10 and #122.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105935	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the facility failed to maintain handrails in a safe, secure, and functional condition for the 200 hallway.The findings include:On 4/6/26 at approximately 11:35 AM during an initial tour, the handrail on the 200 hall outside of room [ROOM NUMBER] was noted to be broken. When pressure was applied to the handrail, the handrail displaced approximately 3 inches vertically. (Photographic evidence obtained)On 4/8/26 at approximately 12:05 PM, a follow-up observation on the broken handrail was conducted with facility's Administrator and Maintenance Director. They both confirmed handrails should be secure to the wall and they confirmed this handrail needed to be repaired. A review of Facility's Maintenance Service policy (dated 12/2009) page #1 of 2 revealed: The maintenance department is responsible for maintaining the buildings, ground, and equipment in a safe and operable manner. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. (Photographic evidence obtained.)