

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: 105975	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Community Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3611 Transmitter Road Panama City, FL 32404	
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 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 upon observations, the facility failed to ensure residents had a clean and sanitary environment as evidenced by residents' personal items not labeled and stored appropriately for each resident in 5 out of 9 rooms sampled. The findings include: An observation was made on the north hallway of Unit 2 on 8/25/25 at 11:00 AM. The following issues were observed: In room [ROOM NUMBER], personal items were not labeled and not separated for each resident residing in the room. In room [ROOM NUMBER], a bedpan was sitting in the bathroom in between the handrail and wall and was not bagged. In room [ROOM NUMBER], a resident's urinal was hanging on the garbage can next to the bed out of the resident's reach. In room [ROOM NUMBER], a bedpan was observed in the bathroom sitting between the handrail and the wall. A second observation was made on this hall on 8/25/25 at 3:00 pm. The following issues were observed. In room [ROOM NUMBER], the personal items sitting in the resident's bathroom was still not labeled or separated for each resident residing in the room. The bedpans in room [ROOM NUMBER] and 236 were still not labeled or bagged and sitting in bathroom in between the handrail and wall. room [ROOM NUMBER]'s urinal was still lying on its side on the bedside cabinet next to the bed. Additional observations made on 08/26/25 at 08:30 am, 11:30 am, and 3:35 pm, on 8/27/2025 at 9:01 am, and 12:00 noon revealed these issues remained uncorrected. In addition on 8/27/2025, room [ROOM NUMBER] was observed with a urine graduate sitting on the handrail in the bathroom.		

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, staff interview, record reviews, and policy review, the facility failed to ensure the provision of care in accordance with professional standards by not ensuring that wound care was provided as stated in the physician order in a timely manner and failed to assess and document a newly identified skin impairment for 2 of 2 residents sampled for non-pressure related skin impairments. (Resident #9 and #106)The findings include: Resident #106 On 8/25/25 at approximately 12:00 PM, an interview and observation was conducted with Resident #106. A Negative Pressure Wound Device (wound vac) was sitting on the bed with the hose not connected to Resident #106. The resident stated it was removed by the nurse at approximately 6:00 AM on 08/25/25 due to becoming loose from the dressing to the lower back surgical wound. A gauze with tape was noted on the lower back with no date present. A Peripherally Inserted Central Catheter (PICC) was in place to the inner right upper arm with the date of 8/14 written on the dressing. On 8/25/25 at approximately 2:05 PM, an observation of Resident #106 was conducted with Nurse A, a Licensed Practical Nurse (LPN). Nurse A (LPN) explained that she was going to replace the Negative Pressure Device and change the PICC line dressing today (8/25/25). Nurse A explained the PICC line dressing was to be changed every Sunday evening. A review of the resident's medical record revealed a physician order on 8/8/25 to apply a wound vac to the surgical incision wound. There was a note by the Nurse Practitioner on 8/11/25 that the wound vac was not started on the resident. Review of the treatment record revealed the following physician's order, Negative pressure wound device settings @ 125mmhg continuous. Cleanse area with Normal saline, pat dry, skin prep peri-wound, apply sponge, secure with negative pressure wound dressing. Every evening shift every 3 day(s) for Negative Pressure Utilization Eval for pain prior to, during, and after treatment and medicate as needed. Monitor site for S/S of infection and notify the Practitioner as needed. Start Date 8/11/25. The resident's medical record revealed the following physician's order for dressing change, Change every week and PRN. Measure length of line and circumference of arm upon admission and insertion then weekly. To measure length, start from hub of PICC line to insertion site on forearm, to measure arm circumference measure at the insertion site around the forearm. Continue weekly until line discontinued. Document the length of line & circumference of arm upon admission and insertion below.MID LINE LENGTH: 13 cm. ARM CIRCUMFERENCE: 25 cm. every evening shift every 7 days for intravenous maintenance. Report signs and symptoms of infections and/or infiltration and/or dislodgement to MD. Change dressing weekly and document measurement of line as needed for IV maintenance. Start Date 8/14/2025. On 8/26/25 at approximately 2:00 PM, the Negative Pressure Wound Device was still on the bed not connected to Resident #106. The PICC line dressing was dated 8/25/25. On 8/26/25 at approximately 3:00 PM, the Negative Pressure Device and dressing change was being completed by Nurse A (LPN) and ADON. At this time the ADON explained the facility had to order more supplies and wait on them to arrive on 8/26/25 to change dressing. The facility policy and procedure titled Catheter Insertion and Care states, The purpose of the policy (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was to change dressings according to physician orders. Step 1of the policy and procedure listed that central venous catheter dressings will be changed at specific intervals, or when needed, to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings. The review of the policy and procedure titled Dressing Change-Non-Sterile and Sterile was conducted. Step 1 of the policy and procedure listed to verify physician order for most current treatment order. Resident #9: An observation of Resident #9 was conducted on 8/25/25 at 2:02 PM. The resident was observed to have a blister on her right lower leg about the size of a quarter. Another observation of Resident #9 was conducted with the Assistant Director of Nursing (ADON) on 8/27/25 at 2:03 PM. A white dressing dated 8/26 was observed in place on the resident's right lower leg. The ADON removed the dressing and stated a blister was under the dressing and was intact. Review of the resident's electronic medical record on 8/27/25 revealed there was no documentation of the blister on the resident's right lower leg and no physician order for a dressing to the blister. A follow-up interview was conducted with the ADON on 8/27/25 at 2:10 PM. The ADON reviewed the electronic medical record and stated there was no documentation of the blister and no physician order for the dressing that was on the resident's right lower leg. She also confirmed the resident's weekly skin check that was due on 8/26/25 was not completed. The facility policy Notification of Change in Condition (CCHC 0625 2016) states, When a resident is determined to have a change in condition, the licensed nurse will evaluate the resident and notify the family/legal representative and the health care provider. Employees shall communicate any information about a resident's status change to the appropriate licensed personnel upon observation. A licensed nurse will perform an evaluation and notify the Health Care Provider as indicated. A licensed nurse is to notify the family/legal representative/resident regarding the resident's change in condition and any new plan of care. The licensed nurse is to implement treatment interventions and any received physician orders. The licensed nurse is to document the notification of change to the family/legal representative/resident and Health Care Provider in the medical record.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to maintain sanitary food practices and ensure kitchen staff wore required hair covering while preparing resident meals. The findings include: On 08/25/2025 at approximately 10:30AM, during kitchen tour with Food Service Director observed staff K cooking lunch without a hair net. Food Service Director asked staff if staff K was wearing a hair net. Staff K stated, No, I am not wearing one. During the same tour at approximately 10:55AM observed in the vegetable freeze a 16 oz Pepsi on the top shelf. Interviewed Food Service Director confirming the drink belong to a staff member. On 8/28/25 at approximately 9:33AM observed staff J cooking meal without facial covering for beard and mustache. Food Service Director informed staff J to put facial covering on. After reviewing emergency food, staff J was still without facial covering. Food Service Director informed staff J to leave the area to put facial covering on.		

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility failed to ensure each resident bedroom was equipped to provide full visual privacy for 1 of 19 sampled resident bedrooms. (room [ROOM NUMBER])An observation of room [ROOM NUMBER]A was conducted on 8/26/25 at 2:09 PM. The room was occupied by a resident. The privacy curtain was observed to be about 3 feet too short in width to provide full visual privacy of the resident. In addition, the existing curtain was stuck and would not pull in the curtain track. Another observation of room [ROOM NUMBER]A was conducted on 8/27/25 at 10:07 AM with the Housekeeping Supervisor. She observed the curtain and stated the track was coming loose from the ceiling and confirmed the curtain was too short in length to provide full visual privacy. (Photographic evidence was obtained.) She stated she had a list of rooms regarding privacy curtain issues that was created on 8/26/25 and room [ROOM NUMBER] was included on the list.		