STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106051	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Bay at Pensacola, LLC	600 W Gregory St Pensacola, FL 32502

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on interviews and record review, the facility failed to ensure the protection of residents' personal privacy and confidentiality of medical information due to staff utilizing personal cellular phones to take photographs and videos of residents for the purpose of communicating clinical concerns to the facility's Nurse Practitioner for 1 of 3 residents reviewed for personal privacy (Resident #2).The findings include: Review of a narrative nursing note, dated 01/20/2026, revealed that Resident #2 was observed by nursing staff sliding himself on the floor while yelling and screaming with abdominal pain.A written email statement by the facility's Nurse Practitioner (NP), dated 01/21/2026, was reviewed. In her statement, she reported that she was contacted by staff who provided a video of Resident #2 and requested clinical guidance based on these behaviors.On 02/09/2026 at approximately 3:35 PM, an interview was conducted with Staff A, Registered Nurse (RN). Staff A stated that, on 01/21/2026, she took a video recording of Resident #2 on her personal cell phone to send to the NP. Staff A acknowledged awareness that the use of personal devices is technically not permitted. She stated she was aware that images were not to be posted on social media. Additionally, she stated that staff also take photographs of resident's skin concerns to send to the nurse practitioner. Staff A stated she was unaware if there were signed consents from residents regarding this form of communication with the facility's practitioners.On 02/10/2026 at approximately 4:20 PM, an interview was conducted with Staff L, Wound Care Nurse. Staff L explained that she routinely uses her personal cell phone to take pictures of residents' wounds and send them via text message to the Nurse Practitioner for assessment and treatment recommendations. She further indicated that this was her routine method of communication where the photographs are stored on her personal device. Staff L stated she was unaware if there were signed consents from residents regarding this form of communication with the facility's practitioners.On 02/11/2026 at approximately 3:30 PM, an interview was conducted with the facility's Administrator. She was informed of staff taking videos and photographs of residents and wounds on personal cellular phones to communicate with the NP, raising confidentiality and Health Insurance Portability and Accountability Act (HIPAA) concerns. The Administrator did not oppose the practice if done for a medical purpose and communication with the NP; however, she could not ensure confidentiality once images were captured and recorded on staff member's personal devices.The facility policy did not provide evidence of consent or authorization of the use of staff's personal devices for capturing, storing, or transmitting resident images, nor evidence of secured, encrypted transmission consistent with privacy standards. Review of the facility's policy titled Videotaping, Photographing, and Other Imaging of Residents, revised 04/2017 revealed the following:Residents will be protected from invasion of privacy and/or abuse that might occur from photographs, videotapes, digital images, and recording during resident care and other facility activities.Staff may not take or reduce images or recordings of any resident without explicit written consent.Transmitting unauthorized images of any resident through e-mail, Internet or social media is considered a violation of resident rights.Residents photographs (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106051	A. Building B. Wing	02/12/2026

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Coral Bay at Pensacola, LLC	600 W Gregory St Pensacola, FL 32502

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	are considered health care records and will be retained and released in accordance with current applicable regulations and statutes governing the release of protected health information.All resident photographs and consents will be retained in accordance with facility policy governing the safekeeping and retention of resident medical records.

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	106051	A. Building B. Wing	02/12/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observations, interviews and record reviews, the facility failed to ensure timely reporting of alleged violations of abuse and neglect within 2 hours in 1 of 7 incident reports reviewed.The findings include:A report of abuse filed on 02/03/2026 at 4:00 PM was reviewed. The report placed the incident on 02/03/2026, however, further review revealed the incident occurred on 01/30/2026. The report stated that the facility Administrator was notified on 02/03/2026, however, the Administrator was aware of the incident that occurred on 01/30/2026. The incident was reported after an investigator from Adult Protective Services entered the facility on 02/03/2026 at 4:00 PM. The summary of the event described Resident #1, a vulnerable adult with cognitive impairment, with her face pressed against the side rails of her bed that sustained physical injuries on 01/30/2026, including puncture wounds to the outside of her cheek requiring sutures and a subsequent transfer to a local hospital.On 02/09/2026 at approximately 2:46 PM, an interview was conducted with the facility Risk Manager. The Risk Manager explained that she decided to report the incident involving Resident #1 after the investigator from Adult Protective Services entered the facility on 02/03/2026 at 4:00 PM to investigate the allegation. She further stated that her expectation is that any suspected abuse observed by staff must be reported immediately so she can initiate an investigation. She defined abuse as including pushing, hitting, kicking, slapping, mocking, verbal threats, or yelling to name a few. She noted that facility Certified Nurse Assistants should report any concerns of abuse to the nurse on duty, who will then contact her directly to begin the investigation. She also stated that any injury of unknown origin must be reported within two hours, after which she will submit a five-day report with the findings of the full investigation. The Risk Manager did not explain her reason for the delay in reporting this incident.Review of the facility policy titled Abuse, Exploitation or Misappropriation-Reporting and Investigating last revised 04/2021 revealed, All reports of resident abuse (including injuries of unknown origin), neglect . are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect . or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as: within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based upon record review and interview, the facility failed to conduct a thorough investigation into allegations of abuse involving 3 of 4 residents (Resident #1, #4, and #9). The findings include:Resident #1Review of the incident report submitted on 02/03/2026 for Resident #1 showed the facility reported that Resident #1 sustained injuries that required a transfer to a higher level of care for medical attention and sutures. The injuries that were documented on 1/30/2026 showed the skin assessment performed on Resident #1 revealed gashes to right chin and jaw. The facility's internal investigation concluded Resident #1 caused the injuries to her own skin by striking her teeth on the siderails. Review of hospital records revealed Resident #1 had 2 lacerations to her right lower face which required repair and an intracranial hemorrhage.An interview was conducted on 02/11/2026 at 1:30 PM with Staff G, Certified Nursing Assistant (CNA). Staff G stated Resident #1's former roommate, Resident #6 had a history of behaviors and becoming upset with other residents at the facility. She recalled Resident #6 had gotten upset with Resident #1 for making noises at one point. Employee G also recalled Resident #6 became upset with another facility resident for sitting in her chair.During an interview on 02/11/2026 at 2:45 PM, the facility Administrator, Director of Nursing, and Risk Manager stated they believed Resident #1 created her injuries by wiggling herself from side to side into the bed siderail. When asked if they had investigated Resident #1's prior roommate, Resident #6 based on her documented history of aggressive behaviors, they stated they had no reason to investigate Resident #6 but that they had moved Resident #1 into a room with a more compatible resident.Review of an email dated 02/05/2026 from Hospice staff revealed they had requested the Administrator move Resident #1 because of concerns about Resident #6's history of violent behaviors. The facility moved Resident #1 five days after she returned from the hospital.Cross reference issues in F689Resident #4Review of the incident report submitted on 02/01/2026 for Resident #4 showed the facility reported an allegation of verbal abuse involving Resident #4. The report stated that Staff Q, Dietary Personnel witnessed Staff S, CNA pull Resident #4 by the arm of his wheelchair and yell at him. The facility's internal investigation concluded the allegation was unsubstantiated, stating they could not gather adequate information from Staff Q due to his resignation. Facility leadership was aware that Staff Q resigned due to workplace harassment after reporting the abuse allegation. The facility Administrator confirmed that no further investigation was conducted. Cross reference F895 for failure to implement retribution policies.Resident #9Review of the incident report submitted on 01/07/2026 for Resident #9 revealed the facility reported an allegation of abuse that Resident #9 stated occurred on 01/06/2026. Resident #9 reported that Staff X, Registered Nurse, became upset with him and threw a clipboard at him. He reportedly used his hand to block her clipboard from hitting his abdomen. Staff documented a bruise on Resident #9's hand after the incident.During an interview conducted on 02/11/2026 at approximately 3:25 PM, the facility Administrator, Director of Nursing, and Risk Manager stated that the Assistant Director of Nursing (ADON) reported Resident #9 had retracted his allegation and had signed something with the Police Department. The facility's internal investigation concluded that the allegation was unsubstantiated based on this reported retraction. The Interdisciplinary Team subsequently added confabulation - allegations of staff abuse dated 1/09/2026 to Resident #9's medical record.When informed that Resident #9 stated he only declined to press charges and did not retract the allegation, the Risk Manager stated Resident #9 was upset about not receiving his medication timely and that was the reason he verbalized the allegation of abuse.Review of the Police Report dated 01/08/2026 revealed the responding officer questioned the Risk Manager why the facility reported the incident two days after it occurred. The Risk Manager stated Adult Protective Services (APS) advised her to call and make the report. The Police (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Report also documented that Resident #9 declined to press battery charges against Staff X.Review of the investigation provided by the facility showed the Risk Manager made a written statement that Resident #9 declined to press charges. No other investigation was provided for review.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on a review of records and staff interviews, the facility failed to ensure that resident assessments and care plans were documented accurately and in a resident-centered manner for 4 of 5 residents reviewed for care plans (Residents #9, #11, #12, and #13) The findings include:During an interview conducted on 02/11/2026 at approximately 11:17 AM, the facility Director of Social Services (DSS), Grievance Officer, and Minimum Data Set (MDS) Registered Nurse (RN) and Licensed Practical Nurse (LPN) were asked about a clinical rationale for labeling Resident #9 with confabulation on the care plans (Confabulation is a neuropsychiatric symptom, often referred to as honest lying, where a person generates false or distorted memories without the intent to deceive. It is not a standalone medical diagnosis but rather a clinical indicator of an underlying neurological or psychological condition.). The MDS LPN identified the DSS as the individual responsible for entering behavior items onto resident's care plans. The DSS indicated that such directives could originate from any member of upper management, including the Administrator, Risk Manager, or Director of Nursing. When asked why Resident #9's care plan for confabulation was added shortly after allegations of abuse, the team did not answer. When asked if they reviewed documentation to support adding confabulation to any resident's care plan, the DSS deferred the responsibility to the Administrator. During a follow up interview conducted on 02/11/2026 at 3:25 PM, the facility Administrator and Director of Nursing (DON) stated that Resident #9 retracted his statement of abuse which was the reason why they added confabulation to his care plan. On 02/12/2026 at 10:01 AM, the DON provided documentation of confabulation being used for Residents #11, #12, and #13. Resident #11 - After 1 grievance where the resident stated, resident says she has not been changed for 30 minutes after activating the call light The summary of the investigation stated, there is some sort of confabulation.Resident #12- Confabulation was used in 4 nurses' notes showing that Resident #12 refused care.Resident #13- Confabulation was used in 1 nurse's note stating that the resident requested to be changed after it had already been done.The administrator and DON did not give further reasoning for why confabulation was being used so frequently in the resident's charts.

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NAME OF PROVIDER OR SUPPLIER Coral Bay at Pensacola, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 W Gregory St Pensacola, FL 32502	

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews and record reviews, the facility failed to take reasonable precautions, including adequate supervision and failed to assess and address the foreseeable risk of harm posed by a resident with documented violent behaviors when roomed with a vulnerable resident and failed to implement sufficient interventions to mitigate that risk for 2 of 10 residents reviewed (Residents #1 and #6)The findings include:Review of medical records dated from 01/01/2026-02/11/2026 revealed Resident #1 was a vulnerable adult with cognitive impairment, who was non-verbal and had limited mobility. Resident #1 sustained unwitnessed physical injuries on 01/30/2026, including lacerations requiring transfer to a higher level of care and medical attention including sutures. Diagnostic testing at the hospital revealed Resident #1 had intracranial bleeding.Resident #6 moved into Resident #1's room on 12/23/2025. A review of Resident #6's clinical record revealed a documented history of aggressive and violent behaviors including yelling and physically acting out towards other residents and staff. Resident #1's record had no documentation to reflect enhanced supervision despite the documented aggressive behavior her roommate had.On 02/11/2026 at approximately 8:45 AM, an interview was conducted with Staff F, Hospice Certified Nursing Assistant (CNA). Staff F reported witnessing Resident #6 verbally cursing at Resident #1 prior to the incident that happened on 01/30/2026.On 02/11/2026 at approximately 1:30 PM, an interview was conducted with Staff G, CNA. Staff G revealed she had discovered Resident #1 on 01/30/2026 with significant amounts of blood on her bed rail, in her mouth, and on the floor surrounding her bed. She recalled in the past, Resident #6 became upset when Resident #1 was making noise and described a prior incident in which Resident #6 had threatened another resident who had sat in her chair. She added that Resident #6 was often verbally abusive to other residents and was physically strong enough to move Resident #1. She then added she had not witnessed any physical altercations between Resident #1 and Resident #6. On 02/11/2026 at approximately 9:56 AM, an interview was conducted with Staff B, Registered Nurse (RN). She confirmed that she initiated the request to transfer Resident #1 to a different room after Resident #1's primary nurse, Staff C, RN, had reported that facility staff notified her of Resident #6 having violent behaviors. Staff B stated that she had an email exchange dated 02/05/2026 after multiple attempts to contact the facility Administrator regarding the request to move Resident #1 to a different room.On 02/09/2026 at approximately 2:46 PM, an interview was conducted with the facility Risk Manager. The Risk Manager explained that, at the time staff discovered Resident #1 with the wounds, the Nurse Practitioner was under the impression that Resident #1's wounds originated internally caused by her teeth because of the presence of blood in her mouth and confirmed that there were no witnesses to the incident. The Risk Manager acknowledged that the punctures were located on the outside of Resident #1's cheek and could not have been caused by her teeth.On 02/11/2026 at approximately 3:30 PM, a combined interview was conducted with the facility Administrator, Director of Nursing (DON), and Risk Manager (RM). They explained that Resident #1 had resided in a different room for several months and was transferred to her new room last week. They explained that Resident #1's room change was initiated by the facility after Resident #1 sustained unwitnessed physical injuries on 01/30/2026 including a laceration requiring transfer to a higher level of care. They indicated the reason for the room change was to improve roommate compatibility with a resident who was similarly alert, talkative, and ambulatory, as they were consider a better match in terms of cognitive status and functional abilities. Regarding the incident for Resident #1 that occurred on 01/30/2026, the Administrator added that, based on observations, statements, and the Nurse Practitioner's assessment, it was believed that the injuries were consistent with contact from the bed side rails and that the injury resulted (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	from the resident's teeth. She explained that her investigation did not include Resident #1's roommate, Resident #6, as she had no reason to believe Resident #6 would have caused the injuries, despite her documented history of aggressive behaviors.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, interviews, and record reviews, the facility failed to ensure a resident's medical record accurately reflected the resident condition for 3 out of 3 resident records reviewed (Resident #1, #2, #9).The findings include: Resident #9 A review of Activities of Daily Living (ADL) task documentation for Resident #9 showed entries indicating that he ambulated 150 feet independently on 02/11/2026 at 3:41 AM, with partial assistance on 02/07/2026 at 2:59 PM, and with supervision on 02/03/2026 at 2:59 PM and 01/31/2026 at 6:59 AM. Documentation also reflected that Resident #9 transferred from bed to chair independently on 02/11/2026 at 3:40 AM, with supervision on 02/03/2026 at 2:59 PM, 01/31/2026 at 6:59 AM, and 01/30/2026 at 6:37 AM. A review of diagnoses confirmed that Resident #9 was a paraplegic. Observations made on 2/11/2026 and 2/12/2026 revealed that Resident #9 was bed bound with no active movement in his lower extremities. During an interview on 2/11/2026 at 2:25 PM, Staff T, Licensed Practical Nurse (LPN) and Staff U, Certified Nursing Assistant (CNA) confirmed that Resident #9 i=was paralyzed and unable to walk or transfer independently. When presented with the above charting entries Staff T and Staff U stated it would be impossible. Resident #1 A review of the clinical record from 01/13/2026 to 02/11/2026 revealed CNA flow sheets that documented Resident #1 as independent with toilet and bed transfer, independent with lower body dressing, call lights within reach and that fluid was provided while the resident was at the hospital. A review of the clinical record for Resident #1 care plan revealed total staff assistance. On 02/09/2026 at approximately 9:00 AM, an observation was made of Resident #1. The resident is lying on her back and has limited body movements. Resident #2 A review of the clinical record from 01/13/2026 to 02/11/2026 revealed CNA flow sheets that documented Resident #2 as independent with toilet transfer and recorded no behaviors. A review of the clinical record dated 02/10/2026, 1/20/2026 and 1/17/2026 reveals nursing documentation of Resident #2, as upset, yelling and screaming. A review of Resident #2's care plan dated 02/02/2026 revealed self-care deficit with total staff assistance with toileting, hygiene, chair/bed transfer and note that the resident is non-ambulatory. On 02/09/2026 at approximately 8:55 AM, an observation was made of Resident #2. He was sliding down on the bed and did not appear to be able to reposition self without assistance. On 02/09/2026 at approximately 9:15 AM, an interview was conducted with Staff E, CNA. He stated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident #1 required total care and had not been able to turn from side to side for several years. He added that she required assistance with feeding. He stated that Resident #2 required total care. On 02/09/2026 at approximately 12:05 PM, an interview was conducted with Staff D, CNA. She explained that patient's behaviors were reported to the nurse and document in the behavior flow sheet.

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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 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Have a Compliance and Ethics Program. Based on observation, interviews, and record review, the facility failed to implement its abuse?prevention and anti?retaliation policies to protect an employee from retaliation and harassment after reporting abuse. (Staff Q) The findings include:During an interview conducted on 02/10/2026 at 10:10 AM, the Dietary Manager reported that Staff Q, Dietary Aide, informed her on 02/09/2026 that he was resigning because staff were harassing him after he reported alleged abuse involving Resident #4. She stated she did not investigate the harassment allegation personally but did notify the facility Administrator and Risk Manager.On 02/10/2026, the 3rd Floor Unit Manager was interviewed and stated she was not present during the abuse incident. In a follow?up interview conducted on 02/11/2026 at 2:45 PM, she acknowledged hearing that Staff Q resigned due to harassment but stated that staff?to?staff harassment was outside her scope and handled by Human Resources (HR).During a group interview conducted on 02/11/2026 at 3:25 PM with the facility Administrator, Director of Nursing (DON), and Risk Manager, the DON and Risk Manager stated Resident #4 was not a reliable witness. The Risk Manager reported she attempted to contact Staff Q twice but was unable to reach him and subsequently unsubstantiated the allegation of abuse and did not investigate further. The Administrator stated she was aware that Staff Q reported being harassed by staff but confirmed no investigation into the harassment had been conducted. Facility leadership stated staff did not witness harassment and they had relied on statements from individuals who were not present during the alleged incident, though the Administrator asserted they were staff from that same area [of the facility] at that same time.At approximately 1:30 PM on 02/11/2026, Staff R, former Dietary Personnel was interviewed. Staff R stating he was calling on behalf of Staff Q, who was anxious about repeated phone calls related to workplace harassment issues. Staff R reported that, during his six months at the facility, he experienced harassment from nursing and kitchen staff and had previously reported the harassment to the facility HR Director, who instructed him to speak with his supervisor. Staff R stated his supervisor was also involved in the harassment, so he did not pursue it further.At 1:36 PM on 2/11/2026, Staff Q was interviewed by phone. Staff Q was noted to be audibly upset. He confirmed he witnessed an incident in which a staff member pulled Resident #4 by the wheelchair arm and said, get your ugly *** out here, and that he immediately reported this to a Unit Manager, who notified the Risk Manager. Staff Q stated that, after reporting the incident, staff spoke loudly about him in a threatening manner, made retaliatory remarks, refused to sign meal?tray forms, and used aggressive tones and profanity toward him. He reported ongoing harassment from both kitchen staff and nursing staff but had difficulty identifying staff because they did not wear name badges. Staff Q stated he resigned by phone due to fear for his safety. He has reported no harassment since leaving his employment and reiterated he could not positively identify all involved staff due to lack of visible name badges.On 02/12/2026 at 9:10 AM, the HR Director stated she recalled Staff R reporting harassment but was unsure of the timeline. She stated Staff R also attempted to report concerns on behalf of another coworker but did not provide a name. She instructed him to report concerns to his supervisor or file a formal grievance so it could be forwarded to the contract company. When informed that staff were not wearing badges, she acknowledged that staff were bad about wearing badges and stated she had repeatedly told them to wear your badges.During an interview on 02/12/2026 at 10:24 AM, Staff T, Dietary Personnel described Staff Q as quiet and respectful. He stated he did not know why Staff Q left but heard he got into it with another nurse or aide and was unsure whether he was fired or resigned. He stated he believed Staff Q did the right thing by reporting abuse and that anyone who witnesses abuse should report it.Review of the facility policy titled Abuse, Neglect, Exploitation or Misappropriation-Reporting and investigating revealed, The administrator ensures the resident and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Coral Bay at Pensacola, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 W Gregory St Pensacola, FL 32502	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or anyone associated with the facility.