

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: 106051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/19/2026
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.			
(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 - Immediate jeopardy to resident health or safety Residents Affected - Many	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 observations and record reviews, the facility failed to provide a safe living environment for 187 of 187 residents by failing to maintain the facility's Automatic Fire Sprinkler System (AFSS). The facility failed to implement proper fire watch protocol per statute to ensure the safety of the residents. This failure in maintaining fire protection equipment and practices has the potential to affect 187 residents. Additionally, the facility failed to store resident care equipment in a sanitary manner in 2 of 7 sampled resident rooms observed. (Rooms 306, 308) Additionally, the facility failed to ensure the environment remained free of potential hazards for 1 of 1 resident reviewed for accidents (Resident #160). The findings include: According to the Life Safety Survey, the facility was notified on 01/14/2026 that it was under Immediate Jeopardy due to the sprinkler system being non-operational since 05/05/2025. The system had been red tagged, indicating it would not perform as required in the event of a fire. Additionally, there were two subsequent red tags on each system, dated from August 2025 and November 2025. The AFSS remained out of service for more than eight months without documented corrective action, interim safety measures, or appropriate notification to regulatory authorities. The facility did not initiate fire watch protocol to ensure the safety of the residents until notified by the Life Safety Surveyor on 1/12/26. This lack of correction provided an unsafe environment for all 187 residents, staff, and visitors for 8 months. During an interview with the maintenance director on 01/12/2026, he confirmed his awareness the AFSS was red-tagged. He stated he had requested repairs from the facility ownership but the repairs were not completed. In an interview with the Administrator on 01/12/2026 she was asked about interim safety measures implemented, including a fire watch. The Administrator confirmed they had not conducted a fire watch following the receipt of the red tags in May. She was unable to provide a reason for the repair delay aside from emails from various vendors showing that additional opinions had been sought by the facility. An interview was conducted with the facility Administrator on 01/12/2026 about what interim safety measures were put in place to ensure the safety of the residents while the sprinkler system and fire pump were red tagged. The Administrator confirmed she was aware the red tags were present since May 2025. The Administrator stated they did not receive confirming documentation from the local fire marshal until October 2025 confirming the problem. The Administrator was unable to provide reason for repair delay aside from emails from various vendors showing that additional opinions were sought. An interview was conducted with the local Fire Marshal on 01/13/2026. He stated he was aware of the red tags on the sprinkler and fire pump systems and that he was under the understanding that the facility was under contract with an engineer for the repairs to be completed. A secondary interview was conducted with the facility Administrator on 01/13/2026 at 10:00 AM. The (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 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administrator was unable to provide interim fire safety plan measures. The Administrator was also unable to provide training to staff regarding fire and evacuation protocols. An interview was conducted with the local Fire Inspector on 01/14/2026. He stated his staff failed to note the red tags in their report written in August 2025. He further stated he was under the understanding that the facility had the system repaired in October 2025. An observation of room [ROOM NUMBER]'s bathroom was conducted on 1/12/26 at 11:00 AM and 2:45 PM, on 1/13/26 at 9:00 AM, 11:12 AM, and 3:10 PM, on 1/14/26 at 10:26 AM and 3:19 PM, and on 1/15/26 at 9:47 AM. Each time, four unlabeled, soiled wash basins, one unlabeled, soiled bedside commode basin, and one unlabeled, soiled toilet hat (used for specimen of urine, stool, kidney stones, etc.) were observed. An observation of room [ROOM NUMBER]'s bathroom was conducted on 1/15/26 at 10:00 AM. An unlabeled, orange-stained urinal bottle was observed sitting on the floor and used adult briefs were observed in the garbage, causing a foul odor. An interview was conducted with Staff W, Licensed Practical Nurse (LPN), who confirmed the unlabeled, soiled personal care items in the bathrooms of rooms [ROOM NUMBERS], stating the items should be labeled with the resident's room number and date. Staff W further stated these items should be cleaned after each use and placed in a plastic bag and stored separately for future use. When asked about the used adult briefs, Staff W stated the adult briefs should have been placed in a garbage bag, tied up and taken to the main garbage outside the resident's room immediately to prevent odors. An interview was conducted with Staff E, Unit Manager (UM) on 11/15/26 at approximately 12:45 PM. Staff E confirmed the findings of unlabeled, soiled personal care items and further confirmed these items should be labeled, cleaned, and bagged. Regarding similar issues, Staff E stated, I am having to check behind most of the staff I have on my floor. Staff E also confirmed that garbage with odors should be taken out of residents' rooms immediately to prevent odors and garbage with no odors should be taken out at the end of each shift or when it is full. 3. During an interview with Resident #160 at approximately 11:23 AM, the resident reported that her cell phone caught fire while it was charging on the window sill on 12/24/2025 at approximately 11:15 PM. She stated the fire alarms were sounding, and she observed the phone actively in flames. The resident extinguished the fire herself using her shoe. She reported that the fire department responded, checked the electrical outlets, and maintenance scraped melted plastic from the window area the next day (Photographic evidence obtained) The windowsill in Resident #160's room was noted to have residual smoke damage and burned plastic consistent with the resident's report of a phone fire on 12/24/2025. Burn marks and soot residue were also visible on the window blinds and window. A staff member provided an account of the fire event that occurred on 12/24/2025. Employee Y, Licensed Practical Nurse (LPN), reported that while staff were walking past Resident #160's room, they observed smoke coming from the doorway. When staff opened the door, the room's smoke detector was activated, but the building fire alarm did not activate. Staff observed a cell phone on the window sill actively on fire while plugged in and charging. The resident extinguished the fire using her shoe. Two residents were evacuated to the dining room for safety. Following the incident, staff reported eye irritation due to smoke exposure. Both residents were assessed and found safe, with no injuries documented. During an interview on 01/18/2026 at 1:43 PM, the Maintenance Director was asked to describe the (continued on next page)		

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F 0584 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Fire Pump including the valve(s) and conduct effective functional testing post-remediation to verify it is operating at 100% on the week of 1/12/26. The Life Safety Consultant re-educated the Maintenance Supervisor and Administrator on Fire Incident Reporting and Systems Failure Fire Incident Reporting Requirement for Agency for Health Care Administration- Florida and Regulatory requirement K353 and K354 initiated on 1/12/26. On 1/13/26 smoking materials were verified as removed from all 30 residents who were care planned to safely maintain their smoking materials independently. Residents were educated by the facility Risk Manager at 1:24pm. Family members and visitors were notified via robocall on 1/15/26 at 8:00 am and 3:00 pm that the facility is currently on a Fire Watch with signage posted 1/14/26 at 3:10pm. Communications included that materials were being removed for the safety of all residents. Care plans were updated for the 30 residents that were assessed to safely hold their smoking materials. The Healthcare Risk Management Consultant/designee, initiated education for facility administration (LNHA and DON) on resident rights to a safe environment initiated on 1/19/26. Verification of the facility's removal plan was conducted by the survey staff on 02/02/2026 and 02/03/2026. The surveyors observed fire watches with 2 staff members on 02/02/26. The surveyors interviewed 10 staff members (including the Administrator and Maintenance Director) and 4 residents regarding the fire watches and removal of smoking materials. The surveyors verified signage was present throughout the facility regarding the fire watches. The surveyors verified education provided to staff from 01/12/26 to 01/14/26 regarding fire watch roles/responsibilities and policies, fire extinguishers, and emergency response. Fire Drills were conducted on 01/21/26, 01/28/26, and 01/29/26 (one on each shift). The surveyors verified the robocalls that took place on 01/15/26 and 01/18/26 regarding fire watch and smoking policies. The surveyors confirmed communication between the facility and the Fire Protection Service company, the Fire Safety and Protection company, the sprinkler vendor company, and the local Fire Marshal. During the survey, the survey staff verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy.		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon interviews, observations, and record and policy reviews, the facility neglected the safety and wellbeing of all 187 residents of the facility by failing to repair the Automatic Fire Sprinkler System (AFSS). The sprinkler system and fire pump have been red tagged since May 5, 2025, with no attempts to fix the problems. The facility failed to implement proper fire watch protocol per statute to ensure the safety of the residents. Additionally, the facility failed to protect residents from abuse for 1 of 3 residents reviewed for abuse. (Resident #205)The findings include: 1) A tour of the facility was conducted on 1/12/2026 by the Life Safety surveyor at 12:00 PM. During this tour, the surveyor noted the automatic fire sprinkler system (AFSS) and Fire Pump were red tagged and had been since 5/5/2025, indicating that the fire suppression system would not function as expected in the event of a fire. As of this annual survey, the facility failed to make the repairs to the automatic fire sprinkler system. Additionally, there were two subsequent red tags on each system, dated from August 2025 and November 2025. An interview was conducted with the facility Administrator on 01/12/2026 about what interim safety measures were put in place to ensure the safety of the residents while the sprinkler system and fire pump were red tagged. The Administrator confirmed she was aware the red tags were present since May 2025. The Administrator stated they did not receive confirming documentation from the local fire marshal until October 2025 confirming the problem. The Administrator was unable to provide reason for repair delay aside from emails from various vendors showing that additional opinions were sought. An interview was conducted with the facility Maintenance Director on 01/12/2026 concurrent with the above observations. The Maintenance Director confirmed he was aware of the tags on the systems and stated he had requested repairs from the facility ownership but the repairs had not been completed. An interview was conducted with the facility Administrator on 01/12/2026 about what interim safety measures were put in place to ensure the safety of the residents while the sprinkler system and fire pump were red tagged. The Administrator could not produce documentation until October 2025 from the local fire marshal confirming the problem. The Administrator was unable to provide reason for repair delay aside from emails from various vendors showing that additional opinions were sought. An interview was conducted with the local Fire Marshal on 01/13/2026. He stated he was aware of the red tags on the sprinkler and fire pump systems and that he was under the understanding that the facility was under contract with an engineer for the repairs to be completed. A secondary interview was conducted with the facility Administrator on 01/13/2026 at 10:00 AM. The Administrator was unable to provide interim fire safety plan measures. The Administrator was also unable to provide training to staff regarding fire and evacuation protocols. An interview was conducted with the local Fire Inspector on 01/14/2026. He stated his staff failed to note the red tags in their report written in August 2025. He further stated he was under the understanding that the facility had the system repaired in October 2025. 2) During record review of Resident #205's medical record, a note was discovered, written on (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	01/13/26 at 9:00 AM by the facility Risk Manager. It stated, This nurse was notified of resident making an allegation of inappropriate conduct related to a prior employee. Resident then began to state that this allegation was against a former therapist who worked here last year and would provide her with exercises and stretches. Resident stated that this alleged staff member wanted her to do 'things'. When asked for clarification, resident stated 'Oral'. I asked resident if she meant 'oral sex' and she stated yes. I asked if alleged staff member requested anything else and she stated 'No, but he would have his crotch in my face when he would roll me on my side to stretch my arm out for exercise. Resident stated that she didn't want to report this, that it was said in confidence. When asked why she didn't report at the time of the allegation, resident stated Because he quit. He was dating a worker here and I didn't want retaliation. When asked if she had ever had any interactions with the named staff member, she stated, No, but I know she can be authoritative. When asked how she knew that, resident confirmed it was via rumor. Resident was asked if she wanted me to the call the police and she stated 'no'. On 1/15/26 at approximately 10:30 AM and approximately 1:15 PM, the Risk Manager (RM) was interviewed about the sexual abuse allegation involving Resident #205 reported on 1/13/26. During the interviews with the RM, the RM acknowledged that sexual misconduct was a form of abuse. On 1/17/2026 at approximately 12:45 PM, an interview was conducted with Resident #205. Resident #205 said she told Staff GG, Physical Therapy Assistant (PTA) in confidence that she was afraid of retaliation and said, They (indicating the facility) talk about a no retaliation policy, but the Certified Nursing Assistants will find a way. Resident #205 explained that she was sexually abused as a child, and when her father found out about the abuse, he was upset and almost went to jail. She stated she did not want anyone to get in trouble, and she was afraid of retaliation from the facility staff. On 1/15/26 at approximately 2:00 PM, an interview was conducted with the Administrator. She stated she had been informed of the allegation that day and had read the RM's note in Resident #205's chart. She stated she had instructed the RM to investigate further and submit a report. She confirmed the report should have been filed on 1/13/26, when the allegation was brought to the staff's attention. A review of Facility's Abuse policy (dated April 2021) reveals: all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft / misappropriation of residents property 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. Under the section policy interpretation and implementation 1) if resident abuse, neglect, exploitation, misappropriation, is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. 2) the administrator or the individual making the allegation immediately reports his or her suspicion to the following agencies, 3) 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. #6) Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents. #11) The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. (Photographic evidence obtained) On 01/19/2026, the facility submitted an acceptable Immediate Jeopardy removal plan which included the following measures: (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Part A: Sprinkler System/Fire Pump The Administrator immediately increased monitoring of the full facility by initiating a Fire Watch on 1/12/26 at 11:00am continuously 24 hours a day, 7 days a week. All residents in the facility were monitored, and there was no adverse outcome to any residents in the building. The Administrator verbally notified the state agency of the Fire Watch on 1/12/26 at 11:00am. The Area Office emailed the Facility on 1/14/26 at 1:20pm regarding the need to notify the Office of Plans and Constructions. The Administrator notified the Office of Plans and Constructions on 1/14/25 at 1:58pm. The survey staff was verbally notified of the Fire Watch on 1/12/26. The 24-hour Fire Watch staff assigned were educated by the facility Director of Nursing and Administrator on role and their responsibilities with a written policy. All staff who worked on January 12, January 13, and January 14 were educated, for a total of 216 of 227 staff members. Education included that this role removes them from any other assignment, provides facility-wide coverage and monitoring resident units every hour with an accountability log. All remaining 11 staff will not be allowed to start their shifts until completion of their education. The Director of Nursing/designee re-educated Fire Watch staff on the use of a fire extinguisher and emergency response initiated on 1/12/26. The Maintenance Supervisor/Designee has overseen and reviewed the documentation of the Fire Watch checks daily initiated on 1/12/26 and 1/13/26. The Director of Nursing/designee educated all staff on fire watch procedures, their individual roles and responsibilities, use of fire extinguisher and emergency response for resident safety, initiated on 1/12/26. 216 of 227 employees (including contracted employees) have been educated. All remaining 11 staff will not be allowed to start their shifts until completion of their education. On 1/12/26 the Facility engaged and signed a contract with the Vendor to replace the sprinkler heads with an anticipated replacement within 30 days. The Facility confirmed L. [NAME] (Fire Protection Service) will be inspecting and remediating the Fire Pump including the valve(s) and conduct effective functional testing post-remediation to verify it is operating at 100% on the week of 1/12/26. On 1/13/26 smoking materials were verified as removed from all 30 residents who were care planned to safely maintain their smoking materials independently. Residents were educated by the facility Risk Manager at 1:24pm. Family members and visitors were notified via robocall on 1/15/26 at 8:00am and 3:00pm that the facility is currently on a Fire Watch with signage posted 1/14/26 at 3:10pm. Communications included that materials were being removed for the safety of all residents. Care plans were updated for the 30 residents that were assessed to safely hold their smoking materials. (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Healthcare Risk Management Consultant/designee, initiated education for all facility staff including the Administrator, Director of Nursing, and the Facility's governing body on incident reporting on 1/20/26. The Healthcare Risk Management Consultant/designee, initiated education for all facility staff including the Administrator, Director of Nursing, and the Facility's governing body on sprinkler system impairments that require reporting and Fire watch initiation which began on 1/20/26. The Healthcare Risk Management Consultant/designee, initiated education for all facility staff on resident neglect on 1/20/26. Part B: Sexual Abuse Allegation &ndash; The alleged perpetrator's (Physical Therapy Assistant) last day of employment was 4/29/2025. The Facility Administration initiated an investigation upon resident allegation of sexual abuse on 1/13/26. The resident alleged the incident occurred sometime between 2/25/25 -4/29/25. The facility investigation included determining if other residents on the alleged perpetrator's assigned caseload were affected including interviewing cognitively intact residents on his assignment and no other residents had concerns of abuse regarding the alleged perpetrator of any other staff. The alleged perpetrator's personnel file was reviewed on 1/13/26 including the pre-employment background check, and there were no adverse findings, allegations, or performance concerns. The certification for PTA was verified to be in good standing. The alleged victim/resident was seen by Psychiatry on 1/12/26, and the resident did not address the allegation with psychiatry. The resident was medically evaluated by a medical provider on 1/14/26, and resident's plan of care was updated to address the allegation on 1/13/2026. The facility reported the allegation on 1/15/26, though the investigated started on 1/13/26. The Risk Management Consultant educated Administrator, Director of Nursing and Facility leadership on the facility abuse and neglect policy and procedure, protection requirements and reporting requirements for abuse and neglect initiated 1/15/26. The Administrator/Designee re-initiated all staff education on the Abuse and Neglect Policy which includes identifying types of abuse and reporting, including sexual abuse, which began on 1/15/26. 177 of 226 employees have been educated on ANE so far. Admin, DON, and Leadership were initially educated on 1/15/26 and then were educated again on 1/19/26. 131 of 226 employees were educated on ANE on 1/15/26 Verification of the facility's removal plan was conducted by the survey staff on 02/02/2026 and 02/03/2026. The surveyors verified in-services were conducted regarding abuse and neglect education on (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	01/14/25, 01/15/26, 01/20/26 and 01/21/26. The surveyors verified the facility submitted incident reports regarding the sexual abuse allegation and verified the facility conducted a thorough investigation of the allegation, including witness statements. The surveyors verified the facility had updated the resident's care plan. The surveyors verified the facility provided a psychiatric consultation for the resident. Interviews with the facility Administrator and Risk Manager were conducted on 02/03/26 to confirm the above information. Interviews were conducted with 6 staff members to confirm their education about abuse and neglect. During the survey, the survey staff verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy.		

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record reviews and interviews, the facility administrative staff failed to use all available resources effectively and efficiently to maintain the facility in a safe manner and ensure the facility's fire suppression system was repaired in a timely manner. The facility Administrator also failed to ensure residents were kept safe from sexual abuse by failing to address a resident's report of staff to resident sexual advances for 1 of 3 resident sampled for abuse. (Resident #205) The findings include: A tour of the facility was conducted on 1/12/2026 by the Life Safety surveyor at 12:00 PM. During this tour, the surveyor noted the Automatic Fire Sprinkler System (AFSS) and fire pump were red tagged and had been since 5/5/2025, indicating that the fire suppression system would not function as expected in the event of a fire. As of this annual survey, the facility failed to make the repairs to the automatic fire sprinkler system. Additionally, there were two subsequent red tags on each system, dated from August 2025 and November 2025. An interview was conducted with the facility Administrator on 01/12/2026 about what interim safety measures were put in place to ensure the safety of the residents while the sprinkler system and fire pump were red tagged. The Administrator could not produce documentation until October 2025 from the local fire marshal confirming the problem. The Administrator was unable to provide reason for repair delay aside from emails from various vendors showing that additional opinions were sought. A secondary interview was conducted with the facility Administrator on 01/13/2026 at 10:00 AM. The Administrator was unable to provide interim fire safety plan measures. The Administrator was also unable to provide training to staff regarding fire and evacuation protocols. 2. During record review of Resident #205's medical record, a note was discovered, written on 01/13/26 at 9:00 AM by the facility Risk Manager. It stated This nurse was notified of resident making an allegation of inappropriate conduct r/t a prior employee. Resident then began to state that this allegation was against a former therapist who worked here last year and would provide her with exercises and stretches. Resident stated that this alleged staff member wanted her to do 'things'. When asked for clarification, resident stated 'Oral'. I asked resident if she meant 'oral sex' and she stated yes. I asked if alleged staff member requested anything else and she stated 'No, but he would have his crotch in my face when he would roll me on my side to stretch my arm out for exercise. It felt good. Resident stated that she didn't want to report this, that it was said in confidence. When asked why she didn't report at the time of the allegation, resident stated Because he quit. He was dating a worker here and I didn't want retaliation. When asked if she had ever had any interactions with the named staff member, she stated, No, but I know she can be authoritative. When asked how she knew that, resident confirmed it was via rumor. Resident was asked if she wanted me to call the police and she stated 'no'. When asked if she felt like this was abuse, she stated, No. On 1/15/26 at approximately 10:30 AM and approximately 1:15 PM, the Risk Manager (RM) was interviewed about the sexual abuse allegation involving Resident #205. During these interviews, the RM confirmed she had not filed an abuse report. She stated her reasoning for not reporting was because Resident #205 was alert and oriented with a Brief Interview for Mental Status (BIMS) (BIMS is a standardized tool used to assess cognitive function) of 15, indicating normal cognitive function. The RM further stated that reporting the incident against Resident #205's wishes would violate her rights. The RM acknowledged that sexual misconduct was a form of abuse, however, she stated she believed that Resident #205 had the right to refuse contacting law enforcement regarding the allegation. On 1/17/2026 at approximately 12:45 PM, an interview was conducted with Resident #205. Resident #205 said she told Staff GG, Physical Therapy Assistant (PTA) in confidence that she was afraid of retaliation and said, They (indicating the facility) talk about a no retaliation policy, but the Certified Nursing Assistants will find a way. Resident #205 explained that she was sexually abused as a child, and when her father found out about the abuse, he was upset and almost went to jail. She stated she did not want anyone to get in trouble, and she was afraid of retaliation from the facility staff. On 1/15/2026 at approximately 10:30 AM, an interview (continued on next page)		

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	conducted with the RM. She acknowledged that she did not file a report based upon Resident #205's accusation. She stated she discussed this with the Administrator, and they decide not to file a report. She stated that she and the Director of Nursing interviewed the resident, but the resident did not want law enforcement notified and did not think it was abuse. She further stated it the resident's right to decline the law enforcement being called. Review of the Administrator Job Description dated 01/01/15 revealed Page 3, section Equipment and Supply Function, bullet 3 states Ensure that the facility is maintained in a clean and safe manner for resident comfort and convenience by ensuring that necessary equipment and supplies are maintained to perform such duties and services. Page 4 section Resident Rights, bullet 9 states report all allegations of abuse and/or misappropriation of resident property. (Photographic evidence obtained)On 01/19/2026, the facility submitted an acceptable Immediate Jeopardy removal plan which included the following measures:The governing body actively engaged RB Health Partners for an Administrator Consultant on 1/14/26 with virtual support and a first on-site visit scheduled for 1/19/26. The Risk Management Consultant provided the Facility's Administrator with training on the QAPI requirements, the QAPI program and plan components including development of a Performance Improvement Program (PIP), safe resident environment, Fire Watch, abuse and neglect, sexual abuse allegations, and corrective action plan(s) to implement and evaluate performance improvement efforts on 1/15/26.An Ad-Hoc QAPI meeting was held with the QAA committee to include the Medical Director to discuss all areas of alleged non-compliance 1/19/26.A Performance Improve Plan was developed by the QAA CommitteeThe initial AD-Hoc QAPI meeting was held on 1/13/26. An additional Ad-Hoc QAPI meeting was held on 1/19/26.Verification of the facility's removal plan was conducted by the survey staff on 02/02/2026 and 02/03/2026.The surveyors interviewed the consultant QAPI personnel to confirm her role and how she is helping the facility ensure they are maintaining the safe resident environment, Fire Watch, abuse and neglect, sexual abuse allegations, and corrective action plans.The surveyors verified the education that was given to the administration (including the Administrator, Director of Nursing, Assistant Director of Nursing, CEO, Social Services, and MDS Coordinator).The surveyors reviewed the QAPI agendas (dated 01/13/26, 01/16/26, 01/28/26) to ensure the committee was discussing all areas of non-compliance.The surveyors reviewed the 4-point action plan to ensure it included information of the fire watch initiative.During the survey, the survey staff verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy.		

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F 0836 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Florida Administrative Code, National Fire Protection Association (NFPA) 101 and interview, the facility failed to comply with Federal, State, and Local Laws and Professional Standards by failing to have a functional fire suppression system since May 5, 2025. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. The findings include: A tour of the facility was conducted on 1/12/2026 by the Life Safety surveyor at 12:00 PM. During this tour, the surveyor noted the Automatic Fire Sprinkler System (AFSS) and fire pump were red tagged and had been since 5/5/2025, indicating that the fire suppression system would not function as expected in the event of a fire. As of this annual survey, the facility failed to make the repairs to the AFSS. Additionally, there were two subsequent red tags on each system, dated from August 2025 and November 2025. Failure to provide a working fire sprinkler is a direct violation of Florida Administrative Code 69A-53.0053- Fire Sprinkler Requirements for Nursing Homes. Failure to have a fire sprinkler system also violates fire protection standards mandated for all nursing homes as outlined in the professional standards of National Fire Protection Association (NFPA) 101 (2012 Edition). Additionally, the facility failed to contact the State Survey Agency about the failure of the fire sprinklers, which is a violation of Florida Administrative Code 59a-4.130, which requires notification within one business day after the occurrence. An interview was conducted with the facility Maintenance Director on 01/12/2026 concurrent with the above observations. The Maintenance Director confirmed he was aware of the tags on the systems and stated he had requested repairs from the facility ownership but the repairs had not been completed. An interview was conducted with the facility Administrator on 01/12/2026 about what interim safety measures were put in place to ensure the safety of the residents while the sprinkler system and fire pump were red tagged. The Administrator could not produce documentation until October 2025 from the local fire marshal confirming the problem. The Administrator was unable to provide reason for repair delay aside from emails from various vendors showing that additional opinions were sought. An interview was conducted with the local Fire Marshal on 01/13/2026. He stated he was aware of the red tags on the sprinkler and fire pump systems and that he was under the understanding that the facility was under contract with an engineer for the repairs to be completed. A secondary interview was conducted with the facility Administrator on 01/13/2026 at 10:00 AM. The Administrator was unable to provide interim fire safety plan measures. The Administrator was also unable to provide training to staff regarding fire and evacuation protocols. An interview was conducted with the local Fire Inspector on 01/14/2026. He stated his staff failed to note the red tags in their report written in August 2025. He further stated he was under the understanding that the facility had the system repaired in October 2025. On 01/19/2026, the facility submitted an acceptable Immediate Jeopardy removal plan which included the following measures: The Healthcare Risk Management Consultant and Facility's Administrator immediately re-reviewed the local, state, and federal laws pertaining to a safe resident environment, notification and inspection requirements including inspection tagging, and sprinkler system and fire pump requirements. The Facility initiated Fire [NAME] on 1/12/26 at 11:00am. The facility notified the local Fire Marshall on 1/12/26 that a fire watch was initiated. The Life Safety Consultant re-educated the Maintenance Supervisor and Administrator on Fire Incident Reporting and Systems Failure Fire Incident Reporting Requirement for Agency for Health Care Administration- Florida and Regulatory requirement K353 and K354 initiated on 1/12/26. The Administrator and Maintenance Director were educated on regulations and laws regarding the sprinkler system and fire pump on (continued on next page)		

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F 0836 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1/12/26.Verification of the facility's removal plan was conducted by the survey staff on 02/02/2026 and 02/03/2026.The surveyors interviewed the consultant QAPI personnel to confirm her role and how she is helping the facility ensure they are maintaining the safe resident environment, Fire Watch, abuse and neglect, sexual abuse allegations, and corrective action plans.The surveyors verified the education that was given to the administration (including the Administrator, Director of Nursing, Assistant Director of Nursing, CEO, Social Services, and MDS Coordinator).The surveyors reviewed the QAPI agendas (dated 01/13/26, 01/16/26, 01/28/26) to ensure the committee was discussing all areas of non-compliance.The surveyors reviewed the 4-point action plan to ensure it included information of the fire watch initiative.During the survey, the survey staff verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy.		

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on record reviews and electronic mail correspondence (email), the governing body failed to assume responsibility for the protection of all 187 residents by failing to act in a timely manner in regard to the failing fire suppression system. The findings include: A tour of the facility was conducted on 1/12/2026 by the Life Safety surveyor at 12:00 PM. During this tour, the surveyor noted the automatic fire sprinkler system (AFSS) and fire pump were red tagged and had been since 5/5/2025, indicating that the fire suppression system would not function as expected in the event of a fire. As of this annual survey, the facility failed to make the repairs to the automatic fire sprinkler system. Additionally, there were two subsequent red tags on each system, dated from August 2025 and November 2025. On 1/17/26 at approximately 4:49 PM an email was sent to the Chief Executive Officer (CEO) who responded on 1/17/26 at 7:30 PM. The following questions and responses were communicated in the email: Were you notified by the facility regarding the fire pump and the sprinkler heads not passing inspection? Yes When were you notified of these issues? On or about May 9, 2025 When and what were your instructions to the facility regarding these issues? I maintained ongoing communication with the facility regarding the inspection findings. Following review of the report, we agreed to engage additional vendors for further evaluation. In July, another company conducted an independent inspection of the sprinkler system and fire pump and downgraded the red tag to yellow. We also retained the contractor that installed the fire pump in 2022, to perform an additional inspection. The three companies were unable to identify a cause for the reduced water output but confirmed that the pump was operating and not at risk of failure. We then pursued testing of the city water pressure through emerald Coast Utilities Authority (ECUA), as this was the only remaining plausible explanation for the change in performance. Although ECUA verbally confirmed that pressure levels were within normal parameters, we have not received written documentation to date. Without this documentation, we have been unable to retain an engineer to conduct a formal water flow study, which would have been the next step. There was no additional information or documentation to show implementation of an effective plan to ensure the residents were protected against the dangers of a fire. On 01/19/2026, the facility submitted an acceptable Immediate Jeopardy removal plan which included the following measures: The governing body actively engaged RB Health Partners for an Administrator Consultant on 1/14/26 with virtual support and a first on-site visit scheduled for 1/19/26. The governing body engaged with the Risk Management Consultant who provided the Facility's Administrator with training on maintaining a safe resident environment, reporting and investigating abuse and neglect, sexual abuse allegations, and corrective action plan(s) to implement and evaluate performance improvement efforts on 1/15/26. The governing body participated in the development of the Fire Watch protocols and the scheduling of repairs initiated on 1/12/26. The governing body members received targeted education by Healthcare Risk Management Consultant/designee on 1/20/2026 regarding roles and responsibilities. The governing body members received education by Healthcare Risk Management Consultant/designee on 1/20/2026 for incident reporting, sprinkler system impairments that require reporting, Fire watch initiation and QAPI oversight expectations. The Administrator immediately increased monitoring of the full facility by initiating a Fire Watch on 1/12/26 at 11:00am continuously 24 hours a day, 7 days a week. All residents in the facility were monitored for resident safety, and there was no adverse outcome to any residents in the building. The Administrator verbally notified the state agency of the Fire Watch on 1/12/26 at 11:00am. The Area Office emailed the Facility on 1/14/26 at 1:20pm regarding the need to notify the Office of Plans and Constructions. The Administrator notified the Office of Plans and Constructions on 1/14/25 at 1:58pm. The survey staff was verbally notified of the Fire Watch on 1/12/26. The 24-hour Fire Watch staff assigned were educated by the facility Director of Nursing and (continued on next page)		

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administrator on role and their responsibilities with a written policy. All staff who worked on January 12, January 13, and January 14 were educated, for a total of 216 of 227 staff members. Education included that this role removes them from any other assignment, provides facility-wide coverage and monitoring resident units every hour with an accountability log. All remaining 11 staff will not be allowed to start their shifts until completion of their education. The Director of Nursing/designee re-educated Fire Watch staff on the use of a fire extinguisher and emergency response initiated on 1/12/26. The Maintenance Supervisor/Designee has overseen and reviewed the documentation of the Fire Watch checks daily initiated on 1/12/26 and 1/13/26. The Director of Nursing/designee educated all staff on fire watch procedures, their individual roles and responsibilities, use of fire extinguisher and emergency response for resident safety, initiated on 1/12/26. 216 of 227 employees (including contracted employees) have been educated. All remaining 11 staff will not be allowed to start their shifts until completion of their education. On 1/12/26 the Facility engaged and signed a contract with the Vendor to replace the sprinkler heads with an anticipated replacement within 30 days. The Facility confirmed the Fire Protection Service company will be inspecting and remediating the Fire Pump including the valve(s) and conduct effective functional testing post-remediation to verify it is operating at 100% on the week of 1/12/26. The Life Safety Consultant re-educated the Maintenance Supervisor and Administrator on Fire Incident Reporting and Systems Failure Fire Incident Reporting Requirement for Agency for Health Care Administration- Florida and Regulatory requirement K353 and K354 initiated on 1/12/26. On 1/13/26 smoking materials were verified as removed from all 30 residents who were care planned to safely maintain their smoking materials independently. Residents were educated by the facility Risk Manager at 1:24pm. Family members and visitors were notified via robocall on 1/15/26 at 8:00am and 3:00pm that the facility is currently on a Fire Watch with signage posted 1/14/26 at 3:10pm. Communications included that materials were being removed for the safety of all residents. Care plans were updated for the 30 residents that were assessed to safely hold their smoking materials. The CEO and another member of the Governing Body were educated on Governing body responsibilities, accountability of QAPI program, incident reporting, the facility sprinkler system and fire pump, fire watch initiation, abuse and neglect including maintaining a safe environment, and QAPI requirements on 1/19/26. Verification of the facility's removal plan was conducted by the survey staff on 02/02/2026 and 02/03/2026. The surveyors observed fire watches with 2 staff members on 02/02/26. The surveyors interviewed 10 staff members (including the Administrator and Maintenance Director) and 4 residents regarding the fire watches and removal of smoking materials. The surveyors verified signage was present throughout the facility regarding the fire watches. The surveyors verified education provided to staff from 01/12/26 to 01/14/26 regarding fire watch roles/responsibilities and policies, fire extinguishers, and emergency response. Fire Drills were conducted on 01/21/26, 01/28/26, and 01/29/26 (one on each shift). The surveyors verified the robocalls that took place on 01/15/26 and 01/18/26 regarding fire watch and smoking policies. The surveyors confirmed communication between the facility and the Fire Protection Service company, the Fire Safety and Protection company, the sprinkler vendor company, and the local Fire Marshal. The surveyors interviewed the consultant QAPI personnel to confirm her role and how she is helping the facility ensure they are maintaining the safe resident environment, Fire Watch, abuse and neglect, sexual abuse allegations, and corrective action plans. The surveyors verified the education that was given to the administration (including the Administrator, Director of Nursing, Assistant Director of Nursing, CEO, Social Services, and MDS Coordinator). The surveyors reviewed the QAPI agendas (dated 01/13/26, 01/16/26, 01/28/26) to ensure the committee was discussing all areas of non-compliance. The surveyors reviewed the 4-point action plan to ensure it included information of the fire watch initiative. During the survey, the survey staff verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy.		

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F 0865 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review, interview, and facility policy review, the facility failed to utilize its Quality Assurance and Performance Improvement (QAPI) process to identify and correct quality deficiencies that posed a likelihood of immediate jeopardy to the health and safety of its residents. The facility failed to report and appropriately respond to a fire event, with prior knowledge that the sprinkler system was not functioning at full operational capacity, placing residents at increased risk for serious harm during an emergency. The findings include: A tour of the facility was conducted on 1/12/2026 by the Life Safety surveyor at 12:00 PM. During this tour, the surveyor noted the automatic fire sprinkler system (AFSS) and Fire Pump were red tagged and had been since 5/5/2025, indicating that the fire suppression system would not function as expected in the event of a fire. As of this annual survey, the facility failed to make the repairs to the automatic fire sprinkler system. Additionally, there were two subsequent red tags on each system, dated from August 2025 and November 2025. An interview was conducted with the facility Administrator on 01/12/2026 by the Life Safety surveyor about what interim safety measures were put in place and fire watch protocol. The Administrator confirmed they were not actively conducting fire watches and had not done any fire watches following the receipt of the red tags on May 5, 2025. During an interview with the Administrator on 01/19/2026, this incident was discussed as part of the facility's QAPI review. The Administrator stated they had discussed the issue in monthly QAPI meetings but had not done a formal Performance Improvement Project (PIP). No reason as to this failure in developing a PIP was given. The facility's QAPI Plan for 2025, under the Maintenance and Engineering section stated, We provide comprehensive building safety, repairs, and inspections to ensure all aspects of safety are enforced, assuring the safety and well-being for each resident, visitor and staff who enter the building. Under the Performance Improvement Projects (PIP) section, it stated, Quality improvement activities are also developed in collaboration with the support of providers, residents, families, and staff. PIPs are implemented in accordance with CMS' protocol including: Measurement of performance using objective quality indicators, Implementation of system interventions to achieve improvement in quality, Evaluation of the effectiveness of the interventions, and Plan and initiation of activities for increasing or sustaining improvement. (Photographic evidence obtained) On 01/19/2026, the facility submitted an acceptable Immediate Jeopardy removal plan which included the following measures: The governing body actively engaged RB Health Partners for an Administrator Consultant on 1/14/26 with virtual support and a first on-site visit scheduled for 1/19/26. The Risk Management Consultant provided the Facility's Administrator with training on maintaining a safe resident environment, reporting and investigating abuse and neglect, sexual abuse allegations, and corrective action plan(s) to implement and evaluate performance improvement efforts on 1/15/26. The facility's QAPI committee convened and implemented a QAPI plan that addresses a safe resident environment initiated on 1/19/26. The QAPI plan includes a continuous, facility-wide Fire Watch with documentation of hourly house-wide rounding, daily compliance auditing of the accountability log, notifications, staff education, Fire Safety rounds, sprinkler system and fire pump repair monitoring, (continued on next page)		

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Keep all essential equipment working safely. Based on observations, record reviews, and interviews, the facility failed to provide a safe living environment for all residents by failing to maintain the Automatic Fire Sprinkler System (AFSS). This can result in the system not activating as designed and has the potential to affect all 187 residents. Additionally, the facility failed to ensure the environment remained free of potential hazards for 1 of 1 resident reviewed for accidents (Resident #160). The findings included: A tour of the facility was conducted on 1/12/2026 by the Life Safety surveyor at 12:00 PM. During this tour, the surveyor noted the automatic fire sprinkler system (AFSS) and fire pump were red tagged and had been since 5/5/2025, indicating that the fire suppression system would not function as expected in the event of a fire. As of this annual survey, the facility failed to make the repairs to the automatic fire sprinkler system. Additionally, there were two subsequent red tags on each system, dated from August 2025 and November 2025. An interview was conducted with the facility Maintenance Director on 01/12/2026 concurrent with the above observations. The Maintenance Director confirmed he was aware of the tags on the systems and stated he had requested repairs from the facility ownership but the repairs had not been completed. An interview was conducted with the facility Administrator on 01/12/2026 about what interim safety measures were put in place to ensure the safety of the residents while the sprinkler system and fire pump were red tagged. The Administrator confirmed she was aware the red tags were present since May 2025. The Administrator stated they did not receive confirming documentation from the local fire marshal until October 2025 confirming the problem. The Administrator was unable to provide reason for repair delay aside from emails from various vendors showing that additional opinions were sought. An interview was conducted with the local Fire Marshal on 01/13/2026. He stated he was aware of the red tags on the sprinkler and fire pump systems and that he was under the understanding that the facility was under contract with an engineer for the repairs to be completed. A secondary interview was conducted with the facility Administrator on 01/13/2026 at 10:00 AM. The Administrator was unable to provide interim fire safety plan measures. The Administrator was also unable to provide training to staff regarding fire and evacuation protocols. An interview was conducted with the local Fire Inspector on 01/14/2026. He stated his staff failed to note the red tags in their report written in August 2025. He further stated he was under the understanding that the facility had the system repaired in October 2025. 2. During an interview with Resident #160 at approximately 11:23 AM, the resident reported that her cell phone caught fire while it was charging on the window sill on 12/24/2025 at approximately 11:15 PM. She stated the fire alarms were sounding, and she observed the phone actively in flames. The resident extinguished the fire herself using her shoe. She reported that the fire department responded, checked the electrical outlets, and maintenance scraped melted plastic from the window area the next day (Photographic evidence obtained) The windowsill in Resident #160's room was noted to have residual smoke damage and burned plastic consistent with the resident's report of a phone fire on 12/24/2025. Burn marks and soot residue were also visible on the window blinds and window. A staff member provided an account of the fire event that occurred on 12/24/2025. Employee Y, Licensed Practical Nurse (LPN), reported that while staff were walking past Resident #160's room, they observed smoke coming from the doorway. When staff opened the door, the room's smoke detector was activated, but the building fire alarm did not activate. Staff observed a cell phone on the window sill actively on fire while plugged in and charging. The resident extinguished the fire using her shoe. Two residents were evacuated to the dining room for safety. Following the incident, staff reported eye irritation due to smoke exposure. Both residents were assessed and found safe, with no injuries documented. During an interview on 01/18/2026 at 1:43 PM, the Maintenance Director was asked to describe the events of 12/24/2025 regarding the fire in Resident #160's room. He stated that Resident #160's cell phone was plugged into the wall and charging on the window sill. He reported that smoke from the phone activated the room smoke alarms. He stated that there was no fire. He confirmed that the sprinklers (continued on next page)		

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F 0908 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	01/15/26 and 01/18/26 regarding fire watch and smoking policies. The surveyors confirmed communication between the facility and the Fire Protection Service company, the Fire Safety and Protection company, the sprinkler vendor company, and the local Fire Marshal. During the survey, the survey staff verified the implementation of the facility's immediate actions to remove the Immediate Jeopardy.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based upon observations, interviews, and facility policy review the facility failed to prevent the spread of infections by not performing hand hygiene during wound care for 5 of 5 residents observed for proper infection control. (Residents #32, #53, #15, #17, #144)The findings include: On 01/13/26 at 12:00 PM, a wound care observation for Resident #53 was conducted with Staff B, Registered Nurse (RN). Staff B did not provide a barrier for clean dressing supplies; she placed clean dressing supplies on his bed. She did not remove her gloves or wash her hands after removing the soiled dressing and prior to applying the clean dressing to cover the resident's wound. 2. On 01/13/26 at 12:20 PM, an observation conducted of Resident #32 revealed a wound to his left heel. He was noted to be on contact isolation for infection of the wound. Staff B did not place a barrier prior to placing clean dressing supplies on Resident #32's bed. After removing the soiled dressing from his left heel, Staff B placed the soiled dressing on the bed next to the clean supplies. Staff B cleaned the wound and applied a clean dressing to left heel without performing hand hygiene and donning clean gloves. Upon exiting Resident #32's room, an interview was conducted with Staff B. Staff B stated the process for wound care was as follows: apply protective equipment, gather supplies, wash hands, place a barrier to prevent soiling of linens and contamination, remove dirty dressing, discard, wash hands, put on clean gloves, clean wound, wash hands, apply clean gloves and then apply clean dressing to wound site. When told about the observations of her wound care, she confirmed, I didn't change my gloves or wash my hands after removing a dirty dressing and before applying a new clean dressing or use a barrier during care. 3. During an observation on 01/13/2026 at 10:34 AM, a tube~feeding bottle for Resident #15 was noted to be hanging from an IV pole, not attached to the resident. The end of the tube feeding tubing was uncapped and open to air, leaving the line exposed to potential contamination. An interview was conducted at this time with Staff X, Licensd Practical Nurse (LPN). Staff X stated she did not know where to obtain a cap for the end of the tube feeding tubing. On 01/14/2026 at 1:09 PM, the surveyor observed Staff K, LPN, performing percutaneous endoscopic gastrostomy (PEG) tube care for Resident #15. (A PEG tube is a feeding tube inserted through the abdominal wall to provide nutrition directly to the stomach.) During this observation, Staff K did not use Enhanced Barrier Precautions (EBP). (Enhanced Barrier Precautions are an infection control strategy used in nursing homes which requires staff to wear personal protective equipment like gowns and gloves during resident care to reduce the spread of drug-resistant organisms) It was noted that EBP signage was posted on Resident #15's room door and a Personal Protective Equipment (PPE) cart was available in the hallway outside the room. Review of Resident #15's clinical record revealed an active provider order requiring EBP for PEG~tube~related care every shift. 4. On 01/13/2026 at 9:30 AM, Staff L, Certified Nursing Assistant (CNA) and Staff M, CNA were observed providing perineal care and indwelling urinary catheter care to Resident #17. Neither CNA performed hand hygiene before beginning care, between perineal care and catheter care, or after completing care. Both CNAs performed perineal care and catheter care using the same pair of gloves (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without removing them or performing hand hygiene between contaminated and clean tasks. After completing care, both CNAs were observed moving between residents without performing hand hygiene after glove removal. An Enhanced Barrier Precautions sign was visible on Resident #17's door. A review of the resident's orders confirmed EBP related to catheter care, and the Treatment Administration Record showed EBP documented every shift. 5. On 01/13/2026 at 9:45 AM, Staff L and Staff M were observed providing perineal care and indwelling urinary catheter care on Resident #144. Neither CNA performed hand hygiene before beginning care, between perineal and catheter care, or after completing care. Both CNAs used the same pair of gloves throughout the care tasks without removing them or performing hand hygiene between contaminated and clean procedures. Employee M was also observed using the same pair of contaminated gloves to open Resident #144's closet and retrieve clean clothing. An Enhanced Barrier Precautions sign was visible on Resident #144's door. A review of the Resident #144's care plan confirmed EBP requirements related to catheter care. An interview was conducted following the observations of Resident #17's and Resident #144's perineal and catheter care. Staff L and Staff M both stated handwashing was not required when wearing gloves. Both CNAs also stated they did not know what Enhanced Barrier Precautions were and incorrectly reported that EBP is the cream used on the bottom after pericare. A review of the facility's policy titled Handwashing/Hand Hygiene, dated August 2019, revealed that the policy states that all personnel must receive ongoing training on hand hygiene, and that staff are required to follow all established handwashing and hand hygiene procedures. The policy further states that hand hygiene supplies, including soap, sinks, towels, and alcohol-based hand rubs, must be easily accessible to staff at all times. The policy outlines the circumstances in which alcohol-based hand rub or soap and water must be used. According to the policy, hand hygiene is required before and after shifts, before and after direct resident contact, before handling clean or soiled dressings, when moving from contaminated to clean body sites, after contact with intact skin, blood, body fluids, contaminated equipment, or resident surroundings, and after removing gloves. Additional provisions in the policy specify that hand hygiene must occur after removing personal protective equipment, and that the use of gloves does not replace the need for hand hygiene. The policy states that disposable gloves are required for aseptic procedures, anticipated exposure to body fluids, and when providing care under contact precautions. The section of the policy addressing glove application and removal instructs staff to perform hand hygiene before applying gloves, to remove gloves using proper technique to avoid contamination, and to perform hand hygiene immediately after glove removal. (Photographic evidence obtained) Interviews with Staff DD, CNA, Staff EE, CNA and Staff W, LPN were conducted on 01/14/2026 at 4:35 PM. Staff DD stated they had been employed at the facility since July 2025. Staff DD stated that Enhanced Barrier Precautions (EBP) meant wearing gloves, gown, and mask in rooms that have an EBP sign posted. Staff EE stated they had been employed at the facility for approximately 4 months. Staff EE stated that EBP involved wearing gloves and a gown when taking care of catheters. Staff W (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated they had been employed at the facility for approximately 5 years. Staff W stated that all rooms with EBP signage should have a cart outside the door, and that staff should be wearing PPE when doing personal care or wound care. Review of Catheter Care Policy A review of the facility's policy titled Catheter Care, Urinary, dated September 2014, revealed that the policy instructs staff to use standard precautions and to maintain clean technique when handling the catheter or drainage system. (Photographic evidence obtained). The procedural steps outlined in the Perineal Care policy (dated February 2018) direct staff to prepare supplies and wash their hands before beginning care, position the resident appropriately and provide privacy, and perform perineal care with soap and water. The policy instructs staff to clean the catheter from the insertion site outward, secure the catheter, check drainage, ensure the resident's comfort, clean equipment after use, and wash their hands again upon completion of the procedure. (Photographic evidence obtained) An interview was conducted on 01/16/2026 at 8:24 AM with the facility's Infection Prevention Nurse. When asked to describe the facility's hand hygiene education, the nurse reported that staff are taught standard handwashing steps, but she was unable to provide specific details regarding the content or method of instruction. She stated that hand hygiene audits are conducted and that a log is maintained. Regarding Enhanced Barrier Precautions (EBP), the nurse reported that EBP education is provided during staff orientation and includes instruction related to catheter care, wound care, colostomy care, and dressing changes. When asked about supply availability, the nurse stated that supplies are kept at the door for residents requiring EBP, and that each hallway has one EBP cart, with unit staff responsible for stocking the carts		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a resident's dignity was maintained by failing to provide appropriate clothing 1 of 6 resident reviewed for dignity (Resident #106).The findings included:A review of Resident #106 Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #106 had Brief Interview for Mental Status (BIMS) (BIMS is a standardized tool used assess cognitive function) of 03, indicating Resident #106 has severe cognitive impairment. Review of this MDS revealed Resident #106 was dependent on staff for her Activities of Daily Living (ADL)On 1/12/2026 at approximately 12:45 PM, Resident #106 was observed sitting in her room in a wheelchair. The resident was dressed in a cardigan with only one middle button secured, with her upper chest and lower abdomen exposed, wearing an adult brief, eating her lunch. Resident #106 stated, I don't have any clothes. The door of Resident #106's closet had a sign indicating her family was responsible for doing her laundry. An observation was conducted of Resident #106's closet. There were no clothes hanging and sheets and a plastic bag of clothes were observed sitting on the bottom of the closet.On 1/13/2026 at approximately 8:30 AM, and 3:00 PM, observations were conducted of Resident #106 lying in her bed. Resident #106 indicated she did not get out of bed because she was not wearing pants and only clothed in a shirt and an adult brief.An interview was conducted on 1/13/26 at approximately 3:05 PM with Staff HH, Certified Nursing Assistant (CNA). Staff HH confirmed Resident #106 did not have clean clothes but she would go to the laundry room to find clothing for her. She confirmed she did not notify the nurse that Resident #106 had no clothes. Staff HH opened Resident #106's closet, and noted there was one pair of pants hanging in the closet.An interview was conducted on 1/13/26, at approximately 3:15 PM with Staff P, Unit Manager (UM.) She confirmed she had observed Resident #106 wearing only a shirt and an adult brief. Staff P inspected Resident #106's closet and noted the jeans. Staff P stated, this should never happen, Staff HH should have dressed [the resident].		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents were able to exercise their rights for care and services regarding scheduled daily routines and failed to provide appropriate therapy or restorative services to improve mobility and strength for 1 of 14 resident reviewed for right to self determination. (Resident #123)The findings included:Review of the facility policy for Activities of Daily Living (ADLs), dated March 2018, revealed residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Policy interpretation and implementation stated: appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing dressing grooming) and mobility (transfer and ambulation). Interviews were conducted on 1/13/26 at 11:45 AM and 1/15/26 at 08:15 AM with Resident #123 who revealed she was unable to get a shower per her preference. She stated, the CNAs [Certified Nursing Assistants] will not get me up out of bed to get in the shower. I prefer to have a shower, but they give me a bed bath instead. I feel cleaner when I have a shower. The CNAs like to fuss at you if you ask for anything and they always say they don't have time to get me up, because it takes a lot of time. On 1/18/26 at 09:00 AM, an additional interview was conducted with Resident #123 who expressed her desire to receive therapy services to gain strength and improve her mobility with transfers. She stated, I have asked multiple times, and they keep telling me that I can't have any therapy or Restorative services because I don't have Medicaid, but once I get Medicaid, they told me that they will see about it then. I'm tired of asking for things because it doesn't do any good. On 01/15/26 at 11:30 AM, a follow up interview was conducted with Resident #123 who stated that Staff R, CNA told her she didn't have time to deal with getting her up on days she is to get a shower and would only give her a bed bath. Review of Resident #123's Minimum Data Set (MDS) dated [DATE] revealed Resident #123's Preferences for Routine and Activities for How important is to you to choose between a tub bath, shower, bed bath, or sponge bath documented her response as very important. Review of Resident #123's Therapy Notes revealed dates of service were 10/7/25 and 10/08/25 and then Resident #123 was discharged from therapy services on 10/08/25 due to benefits exhausted. The Therapy Discharge Note documented Resident #123 required partial to moderate assistance with bed mobility and required substantial maximal assistance with transfers. Skilled interventions for physical therapy evaluation included direct hands-on care with patient. Patient had limited sessions to demonstrate any progressions. Skilled interventions for Occupational Therapy included patient was seen for eval [evaluation] only focusing on establishing baseline, setting goals, and educating patient on use of call light and bed control. A Quarterly Therapy Screen Referral completed on 12/15/26 stated, patient would benefit from continued skilled for ADLs and functional mobility. Recommendations: no skilled therapy intervention indicated. An Interview was conducted with Staff A, Licensed Practical Nurse on 1/15/26 at 11:00 AM revealed (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #123 asked multiple times to get out of bed for a shower, but the staff did not give her a shower. Staff A stated, I have discussed this with the Unit Manager and the CNAs several times, but the CNAs continue to refuse to abide by [Resident #123] wishes and they will mark 'refused' on shower sheets if they don't feel like giving showers.		

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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 observations and interviews, the facility failed to provide appropriate privacy while personal care was being administered by a staff member for 1 of 7 resident reviewed for personal privacy (Resident #62). The findings included: An observation conducted on 1/12/2026 at 1:45 PM revealed Resident #62's room door was fully open, and the privacy curtain was not pulled closed. Continued observation revealed Staff Q, Certified Nursing Assistant was standing at Resident #62's bedside, performing incontinent care. Resident #62 was wearing a facility gown. The gown was pulled up to her upper torso, revealing she was not wearing an incontinent brief. No bed covers were covering Resident #62 during this care. Resident #62's body was exposed and visible from the hallway while other residents were observed passing in front of her room. When Staff Q completed her task, she stated to the surveyor, you can come in, I am just wiping her face now. An interview was conducted with Staff Q at this time. When asked why she had not provided privacy for Resident #62, Staff Q stated, Oh, my bad. Yes, I should have shut her door and pulled the privacy curtain while I was giving her care. Review of Resident 62's medical record revealed she was alert and oriented to self only. She required total assistance from staff with all activities of daily living, including bathing, personal cares, toileting, and dressing. She was incontinent of bowel and bladder and was noted to be dependent on staff for those care and services.		

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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 on record review and interviews, the facility failed to maintain a grievance protocol to properly identify, investigate, and resolve grievances for 1 of 6 resident reviewed for grievances (Resident #123).The findings included:Review of the facility's grievance log was conducted with the Social Worker (SW) and Grievance Official. They both independently reviewed the paper grievance log and compared it with the facility's electronic grievance system.A grievance dated 10/08/25 for Resident #123 was reviewed. The grievance stated, staff refused to dry her after providing incontinence care. The documented Actions stated, It appears to be lunch time when staff cannot toilet residents. The SW acknowledged this was not an appropriate resolution and stated he did not know what actions the unit manager took to address this concern.A grievance dated 11/08/25 for Resident #123 was reviewed. The grievance stated, the resident waited 30 minutes after activating the call light before being changed. The documented Actions stated, some sort of confabulation,. There was no evidence showing how the facility determined the resident was confabulating nor did the grievance have a resolution documented.An interview was conducted on 01/16/26 at 10:39 AM with the Grievance Official. The Grievance Official declined to provide access to notes documenting grievance resolutions.An interview was conducted on 01/16/26 at 12:15 PM with the facility's Administrator during which the grievance process was discussed. The Administrator confirmed the Social Worker (SW) and Grievance Official were not following proper grievance protocol and stated she educated them regarding the protocol. A copy of the facility's policy titled Grievance Policy and Procedure (undated) was obtained. The policy states that the facility will ensure, all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to immediately identify and timely report an allegation of sexual abuse for 1 of 3 residents sampled for abuse. (Resident #205) The findings include: A record review was conducted for Resident #205 revealed a note written by the facility Risk Manager (RM) dated 1/13/26 at 9:00 AM. The note indicated that on 1/13/26, Resident #205 confided in an employee an allegation of inappropriate sexual conduct by a former employee who worked at the facility in the previous year. During interviews on 1/13/26, Resident #205 revealed that a former therapy aide (who no longer works at the facility at the time of the survey) would ask to be her boyfriend and would ask inappropriate things, such as asking for oral sex. On 1/15/26 at approximately 10:30 AM, an interview was conducted with the RM. The RM stated she did not report the abuse to the state agency, citing the resident had the right to decline law enforcement, and that Resident #205 claimed that it was not abuse. On 1/15/26 at approximately 1:15 PM, an additional interview was conducted with the Risk Manager. The RM stated she was not mandated to report the allegation, citing #205's rights, and that Resident #205 had a high cognitive score. On 1/15/26 at approximately 2:00 PM, an interview was conducted with the facility Administrator. She stated she had been informed of the allegation that day and had read the RM's note in Resident #205's chart. She stated she had instructed the RM to investigate further and submit a report. She confirmed the report should have been filed on 1/13/26, when the allegation was brought to the staff's attention. A review of Facility's Abuse policy (dated April 2021) reveals: all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft / misappropriation of residents property 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. Under the section policy interpretation and implementation 1) if resident abuse, neglect, exploitation, misappropriation, is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. 2) the administrator or the individual making the allegation immediately reports his or her suspicion to the following agencies, 3) 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. #6) Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents. #11) The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. (Photographic evidence obtained)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews, record review, and policy review, the facility failed to ensure an allegation of sexual abuse was reported to the State Survey Agency, Law Enforcement, and Adult Protective Services within two hours of the allegation, and failed to ensure a thorough investigation was conducted of the allegation to protect residents for 1 of 1 residents reviewed for mandated reporting (Resident #205) The findings include: During review of Resident #205's record, a note written by the facility's Risk Manager was reviewed. the note was written on 1/13/2026 at approximately 9:00 AM. this note indicated the facility's Risk Manager (RM) and Administrator were told by the Director of Rehabilitation (DOR) of an allegation of sexual misconduct involving Resident #205 and a former employee after it was revealed during a routine interview conducted during the survey process. During interviews on 1/13/26 by the RM, Resident #205 revealed that a former therapy aide (who no longer works at the facility at the time of the survey) would ask to be her boyfriend and would ask inappropriate things, such as asking for oral sex. The facility failed to report the allegation to the state survey agency until 1/15/26 at 5:55 PM, which is fifty-seven hours later. On 1/17/26 at approximately 1:45 PM, an interview was conducted with the DOR. He stated Staff GG, Physical Therapy Assistant (PTA) reported a sexual abuse allegation to him on 1/13/26 between 8:00 AM-9:00 AM, and he immediately notified the Administrator. The DOR stated he did not know any specific details, only that it was a serious sexual allegation, which involved a former employee. He stated that the RM had emailed him on 1/16/26 to request a witness statement. He further stated he replied to the RM's email telling her that he had not spoken with Resident # 205, and that Staff GG had reported the allegation to him. Review of the facility's investigation revealed witness statements and interviews with staff and other residents did not take place until 1/16/26, the day after the report was filed and three days after the allegation was made. On 1/15/26 at approximately 10:30 AM, an interview was conducted with the RM. The RM stated she did not report the abuse, citing the resident had the right to decline law enforcement, and that Resident #205 claimed that it was not abuse. A review of Facility's Abuse policy (dated April 2021) reveals: all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft / misappropriation of residents property 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. Under the section policy interpretation and implementation 1) if resident abuse, neglect, exploitation, misappropriation, is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. 2) the administrator or the individual making the allegation immediately reports his or her suspicion to the following agencies, 3) 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. #6) Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents. #11) The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. (Photographic evidence obtained)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to ensure the Minimum Data (MDS) Assessment accurately coded to reflect active diagnoses for 1 of 4 residents sampled for resident assessments. (Resident # 205)The findings included:Review of Resident #205's electronic medical record (EMR) revealed a Quarterly Minimum Data Set (MDS) dated [DATE] that indicated Resident #205 did not have a diagnosis of Post Traumatic Stress Disorder (PTSD).A review of the Care Plan dated 12/11/2025 revealed that Resident #205 has PTSD related to survivor of sexual abuse/violence as a child, and a car accident, causing major injuries or complications, date 8/31/2022 with a revision on 9/30/2025.A review of Resident 205's diagnoses revealed no medical history of PTSD documented.A review of a Licensed Mental Health Counselor Diagnostic Assessment completed on 7/31/2025 revealed Resident #205 had an extensive history of childhood sexual trauma and that she experienced symptoms and nightmares stemming from two major motor vehicle accidents.On 1/18/26 at approximately 3:00 PM, an interview was conducted with the Staff H, MDS Coordinator. Staff H stated she knew Resident #205 had a history of PTSD. She independently reviewed the most recent MDS assessment, dated 12/11/2025, and confirmed the assessment did not include PTSD as a diagnosis, further stating this was her responsibility and an oversight.		

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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 observations, interviews, policy reviews and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs for 3 of 58 residents sampled. (Residents #10, #17, #181)The findings include: On [DATE] a record review was conducted for Resident #181. The record revealed Resident #181 was dependent on tube feeding for nutrition. The care plan dated [DATE] was reviewed and included the following intervention: Keep head of bed elevated during delivery of feedings, and for the appropriate length of time after feedings. (photographic evidence obtained) Observations conducted on [DATE] at approximately 8:50 AM and 9:15 AM, on [DATE] at approximately 9:00 AM, and on [DATE] at approximately 8:20 AM revealed Resident #181 lying flat on her back with tube feeding infusing. On [DATE] at approximately 8:20 AM, an interview was conducted with Staff P, a Licensed Practical Nurse, (LPN). Staff P stated Resident #181 had contractures in both legs, which made it difficult to raise the head of the bed and the foot of the bed for proper positioning. Staff P stated she would have the therapy department evaluate Resident #181 for proper positioning techniques. Per the facility policy Enteral Feedings-Safety Precautions (last revised [DATE]), Elevate the head of the bed (HOB) at least 30 degrees during tube feeding and at least 1 hour after feeding. (Photographic evidence obtained)2. A record review revealed that a significant change Minimum Data Set (MDS) assessment was completed on [DATE] after Resident #10's re-admission on [DATE] from a hospital stay. Resident #10 elected hospice care due to failing a swallowing test with the likelihood of continued aspiration and chose not to have a feeding tube. The resident also elected his advanced directive to be Do Not Resuscitate (DNR), instructing healthcare providers not to perform cardiopulmonary resuscitation (CPR) on [DATE] with the signature of his Power of Attorney (POA) and physician. A review of the MDS revealed a diagnosis of dementia not related to Alzheimer's. The care plan, with review date of [DATE], revealed no comprehensive based care plan with interventions and goals for dementia or hospice. The advanced directives on the care plan was a full code. An interview was conducted on [DATE] at approximately 10:15 AM with Staff I (MDS Coordinator) regarding the MDS and Care Plan. Staff I confirmed a significant change MDS was completed on [DATE] and the care plan should have been updated to reflect that Resident #10 was admitted to hospice care on [DATE], advanced directives are Do Not Resuscitate (DNR) and dementia not related to Alzheimer's. Staff I stated, It appears the care plan was not updated. Review of the facilities hospice policy (last updated [DATE]) states that coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the provider responsible and discipline assigned to specific tasks) to maintain the residents' highest practicable physical, mental and psychosocial well-being. The coordinated care plan will reflect the resident's goals and wishes, as stated in his or her advanced directives and during ongoing communication with the resident or representative, including palliative goals and objectives; palliative interventions; medical treatment and diagnostic tests. (Photographic evidence obtained) (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Record Review for Resident #17 revealed diagnoses including bilateral below-the-knee amputation. Review of the care plan, last revised [DATE], showed that Resident #17 establishes his own goals, uses a wheelchair for mobility, completed the 8th grade, and enjoys being outdoors in good weather. Review of the electronic chart showed a scanned care plan invitation for a meeting scheduled on [DATE]. A progress note dated [DATE] stated, Resident invited to care plan conference and elected not to attend. Reviewed plan of care. Continue plan of care. Review of the Care Plan Conference Sheet revealed no signature noted from Resident #17. Resident #17 was interviewed on [DATE] at 3:21 PM. He was in bed and stated he had not gotten up that day. When asked why he did not attend the care plan meeting on [DATE], he stated he was not aware of the meeting, never received an invitation, and reported he has never attended a care plan meeting. He stated he never leaves the room. Interview with Employee C (Social Worker) on [DATE] at 2:19 PM revealed he creates printed invitations for the Care Plan Meetings and delivers them to resident rooms. When asked how he ensures the resident received or understood the invitation, Employee C stated he scans the invitation into the electronic chart to show delivery, but acknowledged this does not confirm the resident received or comprehended the notice. When asked about the [DATE] progress note stating the resident elected not to attend, Employee C confirmed he did not ask the resident why he did not attend, did not contact nursing staff, and did not know the reason for the resident's absence. When asked how the resident would get to the conference room, Employee C stated staff would help, but acknowledged he did not notify floor staff that the resident was scheduled to attend. Employee C stated the staff are aware of the resident's schedule. Employee H, Minimum Data Set (MDS) coordinator, was present for the interview, stated care plan meetings can be held at the bedside for residents unable to attend. When asked if this option was offered to Resident #17, Employee C stated, No. Interview with Director of Nursing (DON) on [DATE] at 4:04 PM revealed if a resident is unable to attend a care plan meeting, the SW is expected to ensure the resident is still involved. She stated that care plan meetings can be held at the bedside and that staff are available to assist residents who cannot walk to the conference room. She stated she would expect the SW to contact the resident to determine the reason for non-attendance.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide care and services for 2 out of 3 residents reviewed for activities of daily living (Resident #123 and Resident #108). The findings included: Interviews were conducted on 1/13/2026 at 11:45 AM and 1/15/2026 at 08:15 AM with Resident #123. Resident #123 stated she was unable to get a shower per her preference. She stated, the CNAs (Certified Nursing Assistants) will not get me up out of bed to get in the shower. I prefer to have a shower, but they give me a bed bath instead. I feel cleaner when I have a shower. The CNAs like to fuss at you if you ask for anything and they always say they don't have time to get me up because it takes a lot of time. A follow up interview was conducted on 1/15/2026 11:30 AM with Resident #123. She stated that Staff R, CNA told her that she doesn't have time to deal with getting her up on days she is to get a shower and will only give her a bed bath. An additional interview was conducted on 1/18/26 at 09:00 AM with Resident #123. She stated she wished to receive therapy services to gain strength and improve her mobility with transfers. She stated, I have asked multiple times, and they keep telling me that I can't have any therapy or Restorative services because I don't have Medicaid. But once I get Medicaid, they told me that they will see about it then. I'm tired of asking for things because it doesn't do any good. Review of Resident #123's Minimum Data Set (MDS) dated [DATE] revealed under Preferences for Routine and Activities that it is very important to choose between a tub bath, shower, bed bath, or sponge bath. Review of Resident #123's shower schedule revealed she was scheduled to receive showers or baths every Tuesday, Thursday, and Saturday on the 3:00 PM to 11:00 PM shift. Review of treatment records for 12/01/25 through 1/19/26 revealed the staff documented that Resident #123 received six bed baths and one shower during this lookback period. An interview was conducted with Staff A, Licensed Practical Nurse on 1/15/26 at 11:00 AM. Staff A confirmed she was aware that Resident #123 had asked multiple times to receive a shower, but the staff did not give a shower. Staff A stated, I have discussed this with the unit manager and the CNAs several times, but they continue to refuse and abide by Resident #123's wishes and will mark 'refused' on the shower sheets if they don't feel like giving showers. 2. An interview was conducted on 1/15/26 with Resident #108. Resident #108 stated Staff R does not wipe or clean after I am incontinent. I have not had a shower in about 3 weeks now. She [Staff R] will tell me that 'I don't have time to deal with that today'. Review of Resident #108's medical record revealed she has a Care Plan in place which indicated Resident #108 was incontinent of bowel and bladder and required assistance with toileting / incontinence care needs. The goals indicated Resident #108 was to be kept clean, dry, and odor free with interventions that included provide hands-on assistance with toileting upon resident request and as needed, check resident upon arising, before / after meals and at bedtime for incontinence; perform incontinence care as needed. An additional Care Plan indicated Resident #108 needed assistance with personal care tasks, such as grooming and bathing, and mobility skills. The goals indicate the staff are supposed to assist Resident #108 to maintain her current level of functioning. The interventions included resident is non-ambulatory, dependent on staff for toileting hygiene, and transfers, moderate assistance with showers, dressing. Review of Resident #108's MDS dated [DATE] revealed she had a BIMS (Brief Interview of Mental status) score of 15, which indicates she had normal cognitive function. Under the section for Functional Abilities, the MDS indicated Resident #108 was dependent on staff for toileting and transfers, and required moderate assistance with bathing, dressing, and personal hygiene task. Review of Resident #108's shower schedule revealed she was scheduled to receive showers or baths every Tuesday, Thursday, and Saturday on the 7:00 AM to 3:00 PM shift. Review of treatment records for 12/01/25 through 1/19/26 revealed the staff documented that Resident #108 received two bed baths and six showers during this lookback period. Review of facility policy titled Activities of Daily Living (ADLs) (last updated March 2018) revealed Residents will be provided with care, treatment, and services as appropriate to (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy further stated Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with . hygiene (bathing dressing grooming) and mobility (transfer and ambulation). (Photographic evidence obtained)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide appropriate treatment and services for a resident with limited range of motion to prevent further decline of range of motion for 1 of 7 resident reviewed for range of motion (Resident #132).The findings included:On 1/12/2026 at approximately 3:30 PM, Resident #132 was observed to have bilateral hand and fingers contractures (hardening or shortening of muscles, tendons, or other tissue which can restrict joint mobility). He attempted to pick up a small object from his bedside table with his right thumb and right index finger and demonstrated the difficulty he experienced in grasping a pen. He also attempted to demonstrate opening his right and left hand but was unable to do so. An interview was conducted at this time with Resident #132. He stated he was not receiving therapy services or restorative exercises. Per Resident #132, If they were doing something I wouldn't be in the shape I am in now. Resident #132 stated he did not have splints (rigid devices used to immobilize or support a body part) and was not receiving services. He stated, I did get some exercises from restorative over a year or so ago but nothing since then.On 1/14/2026 at 12:00 PM a follow up interview was conducted and Resident #132 states, I need my fingernail and thumbnail long so I can use them to open my juice and milk, and they assist me in picking up objects from my table. Resident #132 was observed adjusting his bilateral arm sleeves with his right thumb and right index finger during conversation.A record review revealed that he was admitted to the facility on [DATE] with the following diagnoses: Paraplegia post blunt trauma injury with cervical spinal injury, polyneuropathy, contracture of muscle, depression, and hypertension. Review of medical history dated 01/24/2020 revealed that Resident #132 is a functional quadriplegic post boating accident.Upon further review, a Minimum Data Set assessment (MDS) with an assessment date reference of 07/03/2025, showed no signs of delirium, he has little pleasure in doing things and feels down and depressed, it is very important he chooses things in his daily life, has impairment to both upper and lower bilateral extremities, uses a wheelchair for mobility, is dependent for bed mobility, transfers, bathing, dressing, and personal hygiene, is incontinent of bowel and bladder with a colostomy, and no speech therapy, no occupational therapy, no physical therapy, and no restorative nursing program.On 1/17/2026, an order was reviewed for range of motion for restorative services to prevent worsening of BLE (bilateral lower extremities) stiffness for three times a week involving PROM (passive range of motion) followed by stretches 15 reps 2 sets and hold for 3 seconds that was resolved on 6/17/2025. A therapy referral form dated 11/10/2025 requesting therapy services and / or restorative therapy stating Resident #132 would benefit from therapy to improve sitting tolerance and that he would like to use his electric wheelchair, not a regular wheelchair. An interview was conducted with the Director of Rehab (DOR) on 1/17/2026. The DOR stated, [Resident #132] was in the hospital on [DATE] and on 1/3/2025, when restorative services were discontinued due to Resident #132's lack of participation. Progress notes dated 11/24/2023 through 12/27/2024 revealed for the weeks of 6/21/2024, 8/23/2024, and 12/6/2024 that Resident #132 did not complete restorative program those weeks.A follow-up interview was conducted with the DOR and he stated that Resident #132's wheelchair does not work, and he did not participate in restorative services. He confirmed that the resident currently has no skilled therapy. On 1/18/2026 at approximately 11:00 AM, an interview was conducted with the Administrator and Maintenance Director, who stated, If a resident has their own personal electric wheelchair, the facility does not fix them, and outside companies will not come into a facility to work on them. If it's a battery issue then yes, we would get another battery for it. The Maintenance Director stated he was not aware of Resident #132's wheelchair needing any repairs.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, interviews, and facility policy review, the facility failed to ensure the environment remained free of potential hazards for 1 of 1 resident reviewed for accidents (Resident #160). Additionally, the facility failed to assess for safe smoking practices for 1 of 47 residents reviewed for smoking (Resident #78). The findings include: During an interview with Resident #160 at approximately 11:23 AM, the resident reported that her cell phone caught on fire while it was charging on the window sill on 12/24/2025 at approximately 11:15 PM. She stated the fire alarms were sounding, and she observed the phone actively in flames. The resident extinguished the fire herself using her shoe. She reported that the fire department responded, checked the electrical outlets, and maintenance scraped melted plastic from the window area the next day (Photographic evidence obtained) The windowsill in Resident #160's room was noted to have residual smoke damage and burned plastic consistent with the resident's report of a phone fire on 12/24/2025. Burn marks and soot residue were also visible on the window blinds and window. A staff member provided an account of the fire event that occurred on 12/24/2025. Employee Y, Licensed Practical Nurse (LPN), reported that while staff were walking past Resident #160's room, they observed smoke coming from the doorway. When staff opened the door, the room's smoke detector was activated, but the building fire alarm did not activate. Staff observed a cell phone on the window sill actively on fire while plugged in and charging. The resident extinguished the fire using her shoe. Two residents were evacuated to the dining room for safety. Following the incident, staff reported eye irritation due to smoke exposure. Both residents were assessed and found safe, with no injuries documented. During an interview on 01/18/2026 at 1:43 PM, the Maintenance Director was asked to describe the events of 12/24/2025 regarding the fire in Resident #160's room. He stated that Resident #160's cell phone was plugged into the wall and charging on the window sill. He reported that smoke from the phone activated the room smoke alarms. He stated that there was no fire. He confirmed that the sprinklers did not activate. The Maintenance Director stated that the fire department did not respond to the incident. He reported that, after the event, he checked electrical outlets in all rooms and traced the circuits to the breakers, stating that everything was good. No further follow up was made. The Administrator, who was present during the interview, stated that the fire department did respond. The Administrator acknowledged that the incident was not reported to the state agency, despite reporting requirements. The Administrator and Maintenance Director confirmed there was no 2nd floor corridor evacuation conducted and only two residents were moved from the immediate area. 2. On 1/13/26 at approximately 3:00 PM, an observation was conducted of Resident #78 smoking a cigarette. Resident #78 was not noted on the list of known smoking residents provided by the facility. A record review revealed that Resident #78 was admitted to the facility on [DATE] with diagnoses of diabetes type II, hypertension, chronic obstructive pulmonary disease, dyslipidemia, arthritis, and atrial fibrillation (irregular heart rhythm). A review of the record revealed no documentation that Resident #78 was assessed as a safe smoker. On 01/14/26 at approximately 10:15 AM, an interview was conducted with the facility's Risk Manager (RM). She stated Resident #78 had recently started smoking again. She further confirmed the safe smoking assessment and care plan had not been completed by the nursing staff. (continued on next page)		

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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 - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Smoking Policy-Residents (last updated July 2017), revealed The facility shall establish and maintain safe resident smoking practices in the following ways: Prior to, and upon admission, residents shall be informed of the facility smoking policy, including designated smoking areas. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. The resident's ability to smoke safely will be re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff. Residents who have independent smoking privileges are permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited. (Photographic evidence obtained)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, staff interviews, and record review, the facility failed to implement appropriate care, in accordance with current standards of care, to prevent complications of tube feeding for 1 of 3 residents sampled for tube feeding. (Resident #181)The findings include:A review of Resident #181's electronic medical record (EMR) revealed she had a medical history significant for brain injury, chronic respiratory failure, gastrostomy status, muscle wasting, and difficulty swallowing. Review of Resident #181's physician's orders revealed she had an order for nothing by mouth (NPO), head of bed (HOB) elevated 30-45 degrees when tube feeding is administered. Further review revealed no orders were present for snacks or pleasure meals.On 1/13/26 at approximately 8:50 AM, an observation was made of Resident #181 lying in bed. The tube feeding was observed to be infusing at a rate of 55 milliliters (ML) per hour (HR). The head of the bed was mechanically elevated to approximately 30 degrees, however, the resident appeared to have slid down toward the foot of the bed, resulting in a flat (supine) position of the torso.On 1/13/26 at approximately 9:05 AM, an additional observation was conducted of Resident #181 lying flat. An interview and observation were conducted with Staff T, a Licensed Practical Nurse (LPN). Staff T turned off the resident's tube feeding pump and repositioned the resident with the assistance of a Certified Nursing Assistant (CNA). Staff T stated Resident #181 moves around a lot and slips down in bed. Staff T confirmed Resident #181 should be positioned in bed, such that she does not lie flat while her tube feeding is infusing. On 1/14/26 at approximately 9:00 AM, an observation was conducted of Resident #181 once again lying flat in bed. The tube feeding pump was observed to be infusing at 55 ML/HR. The head of the bed was observed to be mechanically elevated at approximately 30-35 degrees. The resident appeared to have slid down towards the foot of the bed, resulting in a flat (supine) position. At this time, Staff P, Unit Manager (UM) observed Resident #181 lying flat in the bed and confirmed the head of the bed should be elevated between 30 and 45 degrees when the tube feeding is infusing.On 1/15/26 at approximately 8:20 AM, an observation was conducted of Resident #181 lying flat in bed for a third time. The tube feeding pump was observed to be infusing at 55 ML/HR. The head of the bed was observed to be mechanically elevated at approximately 30-35 degrees. The resident appeared to have slid down toward the foot of the bed, resulting in a flat (supine) position. Staff P was notified and presented to Resident # 181's room. Staff P stated Resident #181 had contractures in both legs, which made it difficult to raise the head of the bed and the foot of the bed for proper positioning. Staff P stated she would have the therapy department evaluate Resident #181 for proper positioning techniques.Review of the facility policy titled, Enteral Feedings -Safety Precautions, dated November 2018, under the section titled Preventing Aspirations it states the following: Elevate the head of the bed (HOB) at least 30 degrees during the tube feeding and at least 1 hour after feeding. If HOB is medically contraindicated, use the reverse Trendelenburg position (lying on the back) body position where the patient is tilted on an inclined surface, so the feet are higher than the head). (photographic evidence obtained)		

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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 ensure food was stored under sanitary conditions when staff stored a personal, unlabeled insulin pen inside 1 of 3 resident accessible nourishment refrigerators. This practice had the potential to contaminate food items and expose residents to unsafe substances. The findings include: On 01/12/2026 at approximately 9:30 AM, observations were conducted of all nourishment/snack refrigerators, located on multiple floors. All four floors had a nourishment refrigerator, each of which were easily accessible to the residents. During inspection of the 2nd Floor #2 nourishment refrigerator, an unlabeled insulin pen was observed stored in the door shelf. The Dietary Manager, was present and stated the insulin pen was not supposed to be in there. A follow up observation at approximately 11:00 AM revealed the insulin pen was no longer in the refrigerator. Staff interviews were subsequently conducted. Staff L, Certified Nursing Assistant reported the insulin pen belonged to him. He acknowledged he was aware that the nourishment refrigerator was in the dining area and is easily accessible to residents.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observations, record reviews, and interviews, the facility failed to provide an accurate and complete documentation for 2 of 35 residents sampled for medical record review (Resident #5 and #17). The findings included: On 1/13/2026 at 2:06 PM, Resident #5 was observed with a urinary catheter. Closer observation revealed there was orange-colored sediments within the urine. An interview was conducted on 1/14/2026 at 8:45 AM during which Resident #5 was in bed. Resident #5 stated she was waiting for staff to assist her with perineal care. A review of physician's orders revealed an order dated 8/15/24 stated Catheter care with soap and water daily and as needed every night shift. A review of the Treatment Administration Record (TAR) was conducted. The nurse signatures for the areas marked catheter care with soap and water daily and as needed were all blank. On 1/14/2026 at 11:24 AM an interview was conducted with Staff E, a Certified Nursing Assistant (CNA). Staff E stated she performed catheter more than once a shift, but her documentation did not reflect catheter care because the charting was not specific. On 1/14/2026 at 11:38 AM, an interview was conducted with Staff F, unit manager. Staff F reviewed Resident #5's physician orders and confirmed that the catheter care should be documented. 2. Record review for Resident #17 revealed he was a Bilateral Below-the-Knee Amputee Observations were conducted on 01/14/2026 at 10:51 AM, 01/15/2026 at 9:57 AM, and 01/17/2026 at 11:04 AM of Resident #17. During each of these observations, Resident #17 was noted to be lying in bed. During each observation, Resident #17 indicated he had not been out of bed during the day. Review of Resident #17's medical record revealed consistent entries made in the Activities of Daily Living (ADL) documentation by Staff L, Certified Nursing Assistant (CNA) indicating Resident #17 was assisted from bed to chair and ambulated 10 feet and 150 feet. Additional entries documented Resident #17 was assisted to his chair or wheelchair on 01/14/26 and 01/15/26. An interview was conducted on 01/16/2026 at 11:00 AM with the facility Assistant Director of Nursing (ADON). The ADON independently reviewed the ADL documentation for Resident #17. The ADON stated she could not explain why these tasks were documented, as the resident is a bilateral amputee and unable to ambulate. When asked to clarify the documentation, the ADON brought Staff L, CNA into the interview. Staff L stated that sometimes the computer messes up. Staff L further explained when this happened, he would let the nurse know.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and policy review, the facility failed to ensure oxygen cylinders were stored in a safe and secure manner in 1 of 4 designated oxygen storage rooms (3rd floor oxygen storage room). This had the potential to cause fire and hazardous conditions for all 187 residents at the facility. The findings include: On 1/15/2026 at approximately 8:45 AM, an observation was conducted of the 3rd floor oxygen storage room, which revealed one E size oxygen cylinder (a standard, portable high-pressure gas container commonly used in medical settings, particularly for transporting patients, providing emergency backup) was not properly secured within a rack but rather a free standing cylinder at the entrance of the storage room in front of the rack. (Photographic evidence obtained) On 1/15/2026 at approximately 9:25 AM, an interview was conducted with Staff P, the Unit Manager (UM). Staff P confirmed oxygen cylinders were to be stored in racks and the empty oxygen cylinders were stored in a separate rack from the full cylinders. Review of the facility's policy titled, Oxygen Safety, undated, revealed the following, Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. Empty cylinders shall be segregated from full cylinders. Empty cylinders will be marked to avoid confusion. Cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty. (Photographic evidence obtained)		