STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106052	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Havens at Pensacola, The	1900 Summit Boulevard Pensacola, FL 32503

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, record review, and review of the facility policies and procedures, the facility failed to follow infection prevention and control standards including hand hygiene, proper use and ready availability of Personal Protective Equipment (PPE) and storage of oxygen tubing, to prevent the spread of infections by staff involved in direct resident care in 3 of 4 residents observed. (Resident #13, #85, #131)The findings include:1. An observation was conducted outside of Resident #13's room on 5/31/26 at approximately 2:00 PM. It was noted that two signs were posted on the room door, one for contact precautions and one for enhanced barrier precautions (EBP). A personal protective equipment (PPE) cart was located outside the room door; however, closer observation revealed it was out of isolation gowns. (Photographic evidence obtained)An interview was conducted with Staff D, Certified Nursing Aide (CNA) on 5/31/26 at approximately 2:00 PM. After independently inspecting the PPE cart, Staff D confirmed that there was no isolation gowns stocked in the cart. She stated that, when gowns are unavailable and resident care is needed, she would obtain an isolation gown from another PPE cart. After walking to the room another resident who was on EBP precautions and checking that PPE cart, Staff D observed that this cart was also out of isolation gowns. Staff D then proceeded to go to the clean storage room to restock the PPE carts. However, upon entering the clean storage room, Staff D noted this was out of isolation gowns as well. She further explained that she would need to go to the facility's main supply room to restock the gowns.An observation was conducted on 5/31/26 at approximately 3:00 PM of the PPE cart located outside Resident #13's room. It was observed that the PPE cart had been restocked with isolation gowns. Upon entering Resident #13's room, Staff D was observed completing incontinence care to the resident. During this observation, it was noted that Staff D was not wearing the required isolation gown while providing incontinence care to Resident #13 even though Resident #13 was ordered to be on contact precautions and EBP.An interview was conducted with Staff D on 5/31/26 at approximately 3:00 PM following this observation. Staff D confirmed that she was providing incontinence care to Resident #13 without wearing the appropriate PPE/isolation gown as required. She stated that she is aware of the PPE requirements under EBP during resident contact care. She stated that she understood the infection control concerns associated with the failure to do so and added that she had received infection control and PPE education during onboarding when she started at the facility in March 2026.An interview was conducted with Staff B, Registered Nurse (RN) Supervisor on 5/31/26 at approximately 3:05 PM. Staff B confirmed that Resident #13 required appropriate PPE, including isolation gowns, during resident contact care, and that it was the facility's expectation for staff compliance with all infection control practices.An interview was conducted with Resident #13 on 5/31/26 at approximately 3:15 PM. Resident #13 recalled that Staff D had just finished providing her with incontinence care and confirmed that Staff D did not wear a gown during the task. She added that the staff did not always wear gowns while assisting her with care.Review of Resident #13's medical record revealed that she had a stage 4 sacral wound culture positive for MRSA (Methicillin-resistant Staphylococcus aureus-a highly contagious bacterial infection that is resistant to many common antibiotics). Resident #13 was identified as being at risk for complications of infection, and EBP was identified as an intervention to mitigate this risk. Further review of the wound (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care order dated 5/13/26 and 5/27/26 revealed Cleanse sacral wound with Washe and pat dry. Apply Hydrofera Blue to wound bed. Change outer wound dressing to sacrum with bordered foam daily. Cleanse peri wound at 5 o'clock with normal saline and apply Triad paste daily.A wound care observation was conducted for Resident #13 on 6/1/26 at approximately 2:24 PM. Staff C, Registered Nurse (RN) and Staff H, Certified Nursing Assistant (CNA) were present for this observation. After washing hands with soap and water, Staff C donned the appropriate PPE, including an isolation and gloves. Staff C prepared a single cup with wound Washe (a sterile 0.9% sodium chloride [or saline] solution) and Triad paste (zinc oxide-based wound dressing that creates a protective, moisture-retentive barrier). Staff C then gathered the following supplies: sterile 4x4 gauze and a foam dressing. Staff H failed to perform hand hygiene prior to donning PPE and providing resident care. Both staff assisted in providing bowel incontinence care. Staff C then removed the old/contaminated wound dressing from the MRSA positive wound located on Resident #13's sacral area. Staff C then placed the old dressing into the old incontinence brief and placed both items inside of a regular clear garbage bag. Staff C then changed her gloves without performing hand hygiene. Staff C cleansed the sacral wound per physician order with wound Washe. She applied Triad paste to the sterile 4x4 gauze, placed it inside the wound, and covered it with a bordered foam dressing. The ordered Hydrofera Blue dressing (a highly absorbent, antibacterial foam dressing designed to promote moist wound healing) was not applied as prescribed. Upon completion of the treatment, both staff removed their PPE and performed hand hygiene. Staff C then picked up the clear plastic garbage bag containing the contaminated dressing with her bare hands and transported it to the soiled utility room, where it was discarded into the main garbage rather than a biohazard waste bag, failing to ensure proper disposal of contaminated materials and prevention of potential cross-contamination related to MRSA.An interview was conducted with Staff H on 6/1/26 at approximately 2:56 PM following the observation. Staff H acknowledged not performing hand hygiene prior to donning PPE and assisting with Resident #13's care. She stated that she forgot to do so and recognized it was her mistake.An interview was conducted with Staff C on 6/1/26 at approximately 2:59 PM following the observation. Staff C acknowledged that, after providing incontinence care and removing the dressing, she changed her gloves but failed to perform hand hygiene. After reviewing the culture result in the medical record, Staff C confirmed the sacral wound was positive for MRSA. She acknowledged that the contaminated dressing was discarded in a regular garbage bag instead of a biohazard waste bag. After reviewing the active wound care order, she acknowledged that she forgot to apply the Hydrofera Blue dressing as ordered and instead applied a 4x4 sterile gauze. She explained that she became distracted by the incontinence care that was required and forgot to apply the ordered dressing. She stated that she received infection prevention education at least annually and understood the concerns related to cross contamination during the task.An interview was conducted with the facility's Director of Nursing (DON) on 6/2/26 at approximately 1:47PM. The DON explained that her expectations for staff prior to performing wound care was to perform hand hygiene before and after the procedure, review the wound care orders, and gather all the appropriate supplies according to the physician's order.2. An observation was conducted for Resident #131 on 6/1/26 at approximately 1:59 PM. Resident #131 was observed with a dialysis Central Venous Catheter (CVC-a plastic tube inserted into a large vein in the neck, chest, or groin to provide immediate blood access for hemodialysis). Resident #131 was identified as being on EBP as evidenced by signage posted on the room door and PPE supplies available on the PPE cart. During incontinence care provided by Staff K, Licensed Practical Nurse (LPN), and Staff L, LPN, it was observed that neither staff member donned an isolation gown as required under the EBP precautions for resident contact care.An interview was conducted with Staff K on 6/1/26 at approximately 2:05 PM. Staff K acknowledged that Resident #131 was on EBP precautions and that she was not wearing the appropriate PPE, specifically an isolation gown, while performing the incontinence care. She further explained that it was the facility's expectation for staff to utilize appropriate PPE when indicated by appropriate isolation signs. Staff K also stated that she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understood dialysis residents with CVC access were at increased risk for infection.An interview was conducted with Staff L on 6/1/26 at approximately 2:05 PM. Staff L acknowledged not wearing the required isolation gown during incontinence care for Resident #131, who was on EBP.3. An observation was conducted of Resident #85 on 5/31/26 at approximately 4:51 PM. Resident #85 was observed self-propelling from the dining room to her room with an indwelling catheter bag observed hanging below her wheelchair. Closer observation revealed Resident #85 had a dialysis CVC. Observation of Resident #85's room door revealed there was no EBP signage posted on the door and no PPE cart available outside of the room. (Photographic evidence obtained)An observation was conducted of Resident #85 on 6/1/26 at approximately 8:08 AM. Resident #85 was observed sitting in her wheelchair with a portable oxygen tank attached. The oxygen tubing was observed wrapped around the wheelchair's handle and uncovered (Photographic evidence obtained). The resident's nebulizer treatment mask was observed sitting uncovered on the bedside table. Additional oxygen tubing was observed wrapped around a teddy bear on Resident #85's bed and uncovered (Photographic evidence obtained). During this observation, it was noted that no EBP signage was posted on the room door and no PPE cart or supplies available for staff use outside the room.An observation was conducted of Resident #85 on 6/2/26 approximately 8:00AM. Resident #85's oxygen tubing for the portable oxygen tank attached to the wheelchair remained wrapped around the wheelchair's handle, uncovered. Additionally, there continued to be no EBP sign posted on the room door and no PPE cart available outside the room. (Photographic evidence obtained)An interview was conducted with Resident #85 on 5/31/26 at approximately 3:00 PM. Resident #85 explained that she was on dialysis and had recently undergone a procedure to receive the new CVC access in her right chest, as well as an indwelling catheter related to a chronic kidney condition. She further explained that she has been hospitalized many times recently due to kidney complications and recurrent infections.A follow up interview was conducted with Resident #85 on 6/1/26 at approximately 8:08 AM. Resident #85 explained that, during catheter care, staff wore gloves but that the use of isolation gowns was inconsistent.An interview was conducted with the facility's DON on 6/2/26 at approximately 11:25AM. The DON explained that Resident #85 was admitted during a holiday weekend and the omitted EBP signage and PPE cart was an oversight by the facility. She explained that the Infection Preventionist monitored and initiated EBP throughout the facility. She further stated that any nursing staff could initiate and implement isolation precautions for a resident. She confirmed that Resident #81 was a newly admitted dialysis patient with CVC access and an indwelling catheter, which placed her at an increased risk for infection and that EBP should have been initiated upon admission. The DON independently observed the uncovered oxygen tubing wrapped around the wheelchair's handle and stated that it should have been secured and in a bag while not in use. She further stated that it was the facility's expectation, regarding infection control prevention, for nebulizer masks and oxygen tubing to be stored in a dated bag while not in use.An interview was conducted with the facility's Infection Preventionist on 6/2/26 at approximately 2:20PM. He stated that he placed the EBP sign on Resident #85's door and the PPE cart that day. He acknowledged that Resident #85 was at high risk for infections. He explained that if he was not on site, the nursing staff should initiate the isolation precautions and that they had been educated to do so. He confirmed in the case of Resident #85, it was an oversight. Regarding the uncovered nebulizer mask and oxygen tubing, he stated those items should always be placed in a bag when not in use. He acknowledged that those failed practices placed the residents at risk of infection. Review of Resident #85's medical record revealed the resident was re-admitted to the facility with a history of recent sepsis, as a new dialysis patient with CVC access site and an indwelling urinary catheter. Resident #85 was identified as being at risk for complications of infection, with EBP identified as an intervention. Further review of physician orders revealed an electronic order for EBP was entered on 5/27/26.Review of the facility's policy titled Administrating Medications through a small Volume Nebulizer (last revised 1/26) revealed that, when the nebulizer treatment is completed, the equipment will be rinsed and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disinfected. Once dry, it will be stored in a plastic bag labeled with the resident's name and date.Review of the facility's policy titled Enhanced Barrier Precautions (last revised 1/26) revealed, EBPs our infection prevention and control interventions intended to reduce the transmission of multidrug resistant Organism (MDRO) during high contact resident care activities. residents with wounds or indwelling medical devices including central lines and urinary catheters. The policy further revealed that EBPs required the use of gowns and gloves in addition to standard precautions during high contact resident care activities. Gloves and gowns are to be donned prior to resident care and changed before caring for another resident. Examples of high contact care activities included changing briefs, device care, and wound care involving any skin opening requiring a dressing. The policy further revealed that staff were trained on EBP prior to caring for residents, and signs were posted on the door or wall outside the residents' rooms to communicate the type of precaution and personal protective equipment required. PPE equipment and alcohol-based hand rub are readily accessible to staff.Review of the facility's policy titled Dressing, soiled/contaminated (last revised 1/26) revealed, Soiled dressings that are heavily soiled with exudate or drainage or from a resident with an infectious condition must be placed in specially designed by your hazard containers for disposal. Gloves must be worn when changing your dressing and/or when handling items contaminated with blood, body fluid or potentially infective materials.Review of the facility's policy titled Dressings, dry/clean (last revised 1/26) revealed guidelines for dressing applications. The wound care procedure preparation and steps included reviewing the residents care plan, current orders, and treatment record; assembling the required equipment and supplies, including clean dressings, PPE, gowns, gloves, mask, etc., as needed. The procedure steps included:5-Wash and dry hands thoroughly.6-Put on clean gloves Loosen tape and remove soiled dressing.7-Pull glove over dressing and discard into plastic or biohazard bag8-Wash and dry hands thoroughly.9-Open dry, clean dressing(s)10-Label tape or dressing with date, time and initials. Place on clean field.12-Wash and dry hands thoroughly.13-Put on clean gloves.15-Clean the wound with ordered cleanser.16-Use dry gauze to pat the wound dry.17-Apply the ordered dressing and secure with tape or bordered dressing per order.18-Discard disposable items into the designated container.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record and policy review, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication error rate of 8% (2 errors out of 25 opportunities). The findings included: A medication administration observation was conducted with Staff I, Licensed Practical Nurse (LPN) on 6/1/26 at approximately 8:15 AM. Using the electronic medical record, Staff I prepared Resident #81's medications. Staff I was observed retrieving one Olmesartan/amlodipine/hydrochlorothiazide 40/10/25 milligram (mg) tablet (a combination medication used to treat high blood pressure) and one Meclizine 25mg tablet (a medication used to treat dizziness) and placing them into a medication cup. Staff I entered Resident #81's room and placed the medication cup onto the resident's table and stated to Resident #81 here's your medication. The surveyor intervened before Resident #81 ingested the medications and encouraged Staff I to review Resident #81's physician orders. Review of Resident #81's physician orders revealed the order for Olmesartan/amlodipine/hydrochlorothiazide 40/10/25mg included instructions for the staff to give one tablet by mouth daily. Hold if systolic blood pressure is less than 100 for high blood pressure. Further review of the physician orders revealed the order for Meclizine was written for 12.5mg, not 25mg as Staff I was prepared to administer. (Photographic evidence obtained.) An interview was conducted with Staff I on 6/1/26 at approximately 8:30 AM following the observation. Staff I confirmed she was prepared to administer the medications as she had set up. Staff I stated she was unaware of Resident #81's blood pressure status prior to the medication administration observation. Staff I independently reviewed Resident #81's clinical record and stated the last blood pressure had been obtained on 6/1/26 at 6:00 AM. She reviewed the Meclizine label and confirmed it read 25mg. Staff I stated she was unaware the Meclizine she had prepared to administer was the wrong dosage. Staff I confirmed that Resident #81's blood pressure should have been obtained prior to administering the Olmesartan/amlodipine/hydrochlorothiazide. An interview was conducted with Staff J, Unit Manager on 6/1/26 at approximately 9:15 AM, Staff J stated it was her expectation that medications were to be administered according to the physician orders. Staff J stated that required vital signs were to be obtained and nurses were to check the medication for correct dosage prior to administration of any medication.A review of Resident #81's Comprehensive Care Plan included a care plan focus area for at risk for fluctuation in blood pressure with an intervention which instructed staff to administer medications as directed. (Photographic evidence obtained.)A review of facility's policy titled Administering Medications (dated 1/2026) revealed: Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label (3) times to verify the right resident, right medication, right dosage, right time and right method of administration before giving the medication. (Photographic evidence obtained.)