STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106156	A. Building B. Wing	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Pensacola, LLC	1371 West 9 Mile Road Pensacola, FL 32534

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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. (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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to develop a care plan that included services and treatments as well as measurable objectives and timelines to meet the residents' needs for care of an indwelling catheter for 2 of 3 residents reviewed for indwelling catheters. (Resident #1 and Resident #4)The findings include:Resident #4On 11/12/25 at 11:25 AM, an interview was conducted with Resident #4. Resident #4 had an indwelling catheter. Resident #4 stated he was hoping that the facility will have a certain schedule now, since he went to the urologist yesterday. Resident #4 stated he has had a catheter for 14 months and has had multiple urinary tract infections in the past. Resident #4 stated he needed assistance with catheter care and he was hopeful of getting that care now.A review of Resident #4's medical record was conducted. Resident #4 was admitted to the facility on [DATE]. Diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms, hypertension, insomnia, depression, dementia, pain, generalized osteoarthritis, chronic kidney disease, and type 2 diabetes mellitus among others. Physician's orders included changing indwelling urinary catheters every 11th of the month, dated 11/11/25. There were no further orders related to catheter care and services being provided.A review of Resident #4's plan of care revealed only two issues being addressed, one related to risk for falls and another one related to need for enhanced barrier precautions related to indwelling urinary catheter. A nursing progress note dated 11/5/25 indicated the resident had blood in the foley bag when leaving out to go to doctor's appointment.Resident #1A review of Resident #1's medical record was conducted. Resident #1 was admitted to the facility on [DATE] and discharged to the hospital on 7/21/25. Diagnoses included chronic respiratory failure with hypoxia, acute chronic combined systolic congestive and diastolic heart failure, type 2 diabetes mellitus, paroxysmal arthropathy, hypertension, depression, generalized anxiety, body mass index 45.0-49.9 adult, candidiasis of skin and nails, constipation, chronic atrial fibrillation, and presence of urogenital implants. Physician's orders included catheter (diagnosis urinary retention) dated 7/7/25, catheter care every shift dated 7/7/25, catheter change as needed per facility protocol for leakage, dislodgement, obstruction dated 7/7/25, and change foley catheter monthly on the first of the month dated 7/7/25.A review of the care plan stated Resident #1 had a urinary catheter problem but did not include goals and did not include any interventions.Staff interviewsOn 11/12/25 at 12:01 PM, an interview was conducted with Staff A, Regional Nurse Consultant and Registered Nurse (RN). She reviewed Resident #4's medical records and stated the resident should have more than two problems listed on the care plan. She reviewed the physician's orders and stated there should be orders that include frequency of services related to catheter care but there were none.On 11/12/25 at 1:58 PM, an interview was conducted with Staff B, Director of Nursing and RN. She stated she did not know how the facility missed the orders for catheter care for Resident #4. She also stated that the care plans for both residents #4 and #1 should have included services and care for the catheters. She stated she was going to initiate an Improvement plan immediately. A review of facility policy admission Orders dated September 2002 was review. Policy stated, At the time of admission to a healthcare center/agency, in order to assure quality patient/resident care and to comply with Federal law it is necessary that complete and accurate physician orders for the patient/resident's immediate care be obtained. The orders must be reviewed by the admitting nurse and should at least address the patient/resident's dietary needs, medications (if applicable), and routine care to maintain or improve the patient/resident functional abilities. A review of facility policy Care Plans revised 10/21/25 was conducted. Policy stated, Baseline care plan must include the minimum healthcare information necessary to properly care for each patient/resident immediately upon admission, which would address patient/resident specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. Upon a new admission, a baseline care plan will be developed by the admitting nurse/nurses in conjunction with other IDT, the patient/resident and or patient/resident representative. The baseline care plan should be initiated in 24 hours and will be completed and implemented within 48 hours of admission. A comprehensive person-centered care plan will be developed by the interdisciplinary team for each patient/resident within seven days after the completion of the comprehensive assessment. The comprehensive care plan should describe the following: the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being. The care plan approach serves as instructions for the patient/resident's care and provide

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to provide appropriate treatment and services for care of a resident with an indwelling catheter for 1 of 3 resident sampled with indwelling catheters. (Resident #4)The findings include:On 11/12/25 at 11:25 AM, an interview was conducted with Resident #4. Resident #4 had an indwelling catheter. Resident #4 stated he was hoping that the facility will have a certain schedule now, since he went to the urologist yesterday. Resident #4 stated he has had a catheter for 14 months and has had multiple urinary tract infections in the past. Resident #4 stated he needed assistance with catheter care and he was hopeful of getting that care now.A review of Resident #4's medical record was conducted. Resident #4 was admitted to the facility on [DATE]. Diagnoses included benign prostatic hyperplasia with lower urinary tract symptoms, hypertension, insomnia, depression, dementia, pain, generalized osteoarthritis, chronic kidney disease, and type 2 diabetes mellitus among others. Physician's orders included changing indwelling urinary catheters every 11th of the month, dated 11/11/25. There were no further orders related to catheter care and services being provided.A review of Resident #4's plan of care revealed only two issues being addressed, one related to risk for falls and another one related to need for enhanced barrier precautions related to indwelling urinary catheter. A nursing progress note dated 11/5/25 indicated the resident had blood in the foley bag when leaving out to go to doctor's appointment.On 11/12/25 at 12:01 PM, an interview was conducted with Staff A, Regional Nurse Consultant and Registered Nurse (RN). She reviewed Resident #4's medical records and stated the resident should have more than two problems listed on the care plan. She reviewed the physician's orders and stated there should be orders that include frequency of services related to catheter care but there were none.On 11/12/25 at 1:58 PM, an interview was conducted with Staff B, Director of Nursing and RN. She stated she did not know how the facility missed the orders for catheter care for Resident #4. She also stated that the care plans for both residents #4 and #1 should have included services and care for the catheters. She stated she was going to initiate an Improvement plan immediately. A review of facility policy admission Orders dated September 2002 was review. Policy stated, At the time of admission to a healthcare center/agency, in order to assure quality patient/resident care and to comply with Federal law it is necessary that complete and accurate physician orders for the patient/resident's immediate care be obtained. The orders must be reviewed by the admitting nurse and should at least address the patient/resident's dietary needs, medications (if applicable), and routine care to maintain or improve the patient/resident functional abilities. A review of facility policy Care Plans revised 10/21/25 was conducted. Policy stated, Baseline care plan must include the minimum healthcare information necessary to properly care for each patient/resident immediately upon admission, which would address patient/resident specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. Upon a new admission, a baseline care plan will be developed by the admitting nurse/nurses in conjunction with other IDT, the patient/resident and or patient/resident representative. The baseline care plan should be initiated in 24 hours and will be completed and implemented within 48 hours of admission. A comprehensive person-centered care plan will be developed by the interdisciplinary team for each patient/resident within seven days after the completion of the comprehensive assessment. The comprehensive care plan should describe the following: the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychological well-being. The care plan approach serves as instructions for the patient/resident's care and provide continuity of care by all partners.