STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105328	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Rosa Center for Rehabilitation and Healing	5386 Broad St Milton, FL 32570

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a record review, interviews, and review of facility policy, the facility failed to prevent new skin breakdown from occurring for 1 of 3 residents reviewed for pressure ulcers (Resident #3).The findings include:Review of Resident #3's medical record revealed he had been admitted to the facility on [DATE] for respite services. Resident #3 had a medical history significant for Alzheimer's, dementia, and a stroke in 2024 which caused him to have left sided weakness. Review of Resident #3's Baseline Care Plan revealed the section for skin breakdown was left blank. A Skin Risk Assessment performed on 04/24/26 identified that Resident #3 was at moderate risk for skin breakdown. Further review of the medical record showed that an admission Skin Assessment form completed on 04/25/26 documented no evidence of skin breakdown upon admission. A subsequent Skin Assessment form, documented on 04/29/26 (the date of discharge) at 10:02 AM revealed the presence of redness and a small blister on the right side of Resident #3's body. Review of a Progress Note dated 04/29/26 at 11:25 AM revealed that Resident #3 was discharged home accompanied by his wife. However, no documentation was found regarding the noted skin breakdown that had been documented on the Skin Assessment form earlier that morning. An interview was conducted with Resident #3's spouse on 06/01/26 at approximately 4:02 PM. She stated that Resident #3 had acquired new skin break down during the 5-day respite stay at the facility. The spouse stated she had informed the Assistant Director of Nursing (ADON) of the skin breakdown prior to Resident #3's discharge and that the ADON had documented a Skin Assessment form on 04/29/26 at 10:02 AM prior to Resident #3's discharge from the facility. An interview was conducted with the facility's Wound Care nurse on 06/02/26 at approximately 1:47 PM. The Wound Care nurse stated that staff completed full skin assessments on every resident upon admission. She explained that if a resident developed any skin breakdown during their stay, she would notify the resident's family and the physician for wound care orders. She stated she was unaware of Resident #3 having skin breakdown during his stay at the facility. Given the time to independently review Resident #3's Skin Assessments, the Wound Care nurse confirmed that the admission Skin Assessment done on 04/24/26 showed no skin breakdown. She further confirmed that the discharge Skin Assessment done on 04/29/26 documented new areas of skin breakdown. After reviewing the chart, she noted that there was no documentation of the physician or family being notified of this change in condition. An interview was conducted with Staff H, Unit Manager on 06/02/26 at approximately 2:15 PM. Staff H explained that any skin conditions acquired during a resident's stay were promptly reported to both the resident's family and physician. Staff H further stated these notifications, along with any resulting new physician orders, would be documented in the resident's medical record. Given the time to independently review Resident #3's admission and discharge Skin Assessments, Staff H confirmed that Resident #3 developed new skin breakdown during his respite stay and found no additional documentation indicating any follow^up actions made by the ADON. A review of the facility's policy titled Skin and Wound Management (undated) revealed nurses were required to conduct and document regular skin inspections using the Skin Sweep form at admission and weekly. The policy also required obtaining a physician's order when skin impairment was identified and notifying the resident's representative to discuss interventions that supported wound healing.

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