

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: 105328	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Santa Rosa Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, resident interview, staff interviews, record review, and policy review, the facility failed to ensure the interdisciplinary team assessed and determined residents were capable of self-administration of medications prior to allowing 1 of 20 sampled residents to self-administer medications. (Resident #2) The findings include: An observation of Resident #2 was conducted on 12/1/25 at 11:41 AM. The resident was in bed and a green, round pill was observed in a medication cup on top of the overbed table. The resident stated the medication was a Tums (a medication used for upset stomach and nausea) and that the nurse brought it in a while ago. (Photographic evidence was obtained.) A review of Resident #2's electronic medical record revealed the resident had a current physician order dated 10/26/23 for Tums oral tablet chewable 500 mg give one tablet two times a day for gastroesophageal reflux disease. A review of the quarterly minimum data set with an assessment reference date of 11/13/25 revealed Resident #2 had a brief interview of mental status score of 15, indicating the resident was cognitively intact. The record revealed no assessment or care plan for Resident #2 to self-administer medications. A telephone interview was conducted with Employee A (Licensed Practical Nurse), who worked on 12/1/25 and would have administered this medication. She stated she gave Resident #2 her 9:00 AM medications on 12/1/25. She stated she did not observe the resident ingest her Tums, but acknowledged she was supposed to observe the resident take the medication. An interview was conducted with the Director of Nursing (DON) on 12/3/25 at 11:10 AM. The DON stated the nurse is expected to observe the resident ingest the medications. An additional interview was conducted with the DON on 12/4/25 at 9:20 AM. The DON confirmed Resident #2 was not assessed or care planned to self-administer medications. Review of the undated facility policy for Administration of Drugs revealed self-administration of drugs is permitted when approved by the interdisciplinary team, including the physician, and documented.		

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 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. Based on observations, record review, staff interview, and policy review, the facility failed to implement the plan of care for 1 of 1 sampled resident reviewed for edema. (Resident #103)The findings include:Observations of Resident #103 were conducted on 12/2/25 at 12:05 PM and 12/3/25 at 11:35 AM. During both observations, the resident was sitting in his wheelchair with no compression stockings on his lower extremities. A review of Resident #103's electronic medical record revealed the resident had a current diagnosis of edema and a current physician order dated 11/13/25 for compression stockings to bilateral lower extremities when out of bed as tolerated. A review of the current medication and treatment records revealed no indication of the use of compression stockings. A review of the resident's current plan of care for risk of complications related to Cerebrovascular Accident revealed an intervention dated 11/14/25 for compression stockings to bilateral lower extremities when out of bed as tolerated. An interview was conducted with Employee B (Licensed Practical Nurse) on 12/3/25 at 12:16 PM. Employee B stated Resident #103 did not wear compression stockings and she did not believe he had a physician order for compression stockings. On 12/3/25 at 12:18 PM, Employee B reviewed Resident #103's medical record and confirmed the physician order for compression stockings was not placed in the electronic system correctly and did not populate the treatment record to implement the order. An interview was conducted with the Director of Nursing (DON) on 12/3/25 at 12:23 PM. The DON confirmed the physician's order for compression stockings was not populated to the medication or treatment record. Review of the facility policy for Resident Assessment Instrument Comprehensive Care Plan effective September 2024 revealed: The facility will utilize the Resident Assessment Instrument process to assess residents' needs, develop individualized care plans, and ensure the delivery of quality care. This process will involve interdisciplinary team members and be revised to reflect resident condition changes.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, record review, staff interviews, and policy review, the facility failed to ensure Certified Nursing Assistants demonstrated competency during care to ensure resident safety for 1 of 4 sampled residents reviewed for accidents. (Resident #50) The findings include: An observation of Resident #50 was conducted on 12/2/25 at 10:12 AM. During the resident's interview, the resident initiated her call light and stated her neck was itching. Employee C (Certified Nursing Assistant) answered the resident's call light. Resident #50 asked Employee C to obtain a tube of cream from her bedside nightstand drawer and apply the cream to her neck. Employee C obtained the tube of Clotrimazole-Betamethasone Dipropionate cream 1- 0.05% and applied the cream to the resident's neck. Clotrimazole-Betamethasone Dipropionate cream is a prescription topical cream used to treat fungal skin infections. A review of Resident #50's current physician ordered medications revealed an order dated 11/25/25 for Clotrimazole-Betamethasone External Cream 1-0.05 % (Clotrimazole w/ Betamethasone) - apply to rash topically every day and evening shift. Apply to neck, back, arms, and upper chest. An interview was conducted with Employee C on 12/2/25 at 2:35 PM. Employee C stated the nurses in the facility allow her to apply prescription creams to residents. She stated she knew she was not supposed to do so. An interview was conducted with the Director of Nursing (DON) on 12/2/25 at 2:38 PM. The DON stated she expects the nurses to apply prescription creams to residents and keep them in the treatment cart. Review of the undated facility policy for Administration of Drugs revealed: Drugs and biologicals may be administered only by licensed physicians, licensed registered or practical nursing personnel, or by other personnel who are duly authorized to perform such services under state law.		