STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105552	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandy Ridge Center for Rehabilitation and Healing	5360 Glover Lane 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 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, interviews, and record reviews, the facility failed to implement and maintain accident?prevention interventions for 1 resident (Resident #1) who previously sustained a fall with major injury, resulting in the resident experiencing a second preventable injury. The facility did not follow the resident's updated care plan requiring two?person assistance for bed baths only and allowed the resident to be taken to the shower despite this restriction. This failure resulted in the resident sustaining a humerus fracture and placed the resident at continued risk for further avoidable harm. This deficient practice is cross?referenced to F0689 due to the facility's failure to provide adequate supervision and accident?prevention interventions. The findings include:A record review of Resident #1's chart on 02/25/2026 revealed that she had a right closed hip fracture and displaced hip following a fall from the bed on 09/29/2025. The facility reported the following corrective action after the incident: All bed baths for [Resident #1] are now conducted with two person assistAn interview and observation of Employee B, a Certified Nursing Assistant (CNA), on 02/25/2026 at 11:19 AM revealed that the facility uses a sticker system outside each resident's door to indicate the required level of assistance, with 1P meaning one?person assist and 2P meaning two?person assist. An observation of the sticker outside Resident #1's room indicated she requires a two?person assist.An interview with two of Resident #1's daughters on 02/25/2026 at 11:30 AM revealed that the resident had recently sustained an injury to her left shoulder, and an X?ray confirmed a humerus fracture. The resident's daughter stated that Resident #1 was able to describe the event, telling them, I was brought to the shower room, they pulled on my arm, and hurt me. They further explained that an investigator reviewed the incident and closed the case after determining the fracture was pathological and related to the resident's history of osteopenia. Following this event, the daughter reported attending a meeting where it was agreed that Resident #1 would receive bed baths only, with two staff assisting. A sign reading 2 person bed baths only was observed above Resident #1's bed, and the daughter confirmed it had been placed there after the September 2025 fall from the bed. The daughter stated that Resident #1 was complaining of shoulder pain 2 days before the x-ray and Employee D, a Licensed Practical Nurse (LPN), was made aware.A review of the Resident #1's Xray report for 01/05/2026 showed an acute left humeral fracture.An interview with Employee D on 02/25/2026 at 1:20 PM revealed that she notified the Nurse Practitioner in January about Resident #1's increased pain and subsequently received orders for an X?ray and additional pain medication. She further stated that after Resident #1's first injury, the facility revised its practice to require two?person assistance for bed baths for residents on hospice or those with limited mobility in bed.A review of Resident #1's revised care plan revealed that the following:09/30/2025 (After hip fracture)- The resident is dependent with staff of 2 persons for bathing/showering 3 times per week as tolerated and as necessary.10/02/2025- The resident is dependent with staff of 2 persons for bathing/showering 3 times per week as tolerated and as necessary. Cloth bed pad to be placed under the resident (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when bathing.10/02/2025- The resident is dependent with staff of 2 persons for bathing 3 times per week as tolerated and as necessary. Cloth bed pad to be placed under the resident when bathing.1/7/2026 (after humerus fracture)- The resident is dependent with staff of 2 persons for bathing/showering 3 times per week as tolerated and as necessary. Cloth bed pad to be placed under the resident when bathing.A review of Resident #1's bath documentation showed inconsistent adherence to the care plan interventions following her fall?related hip fracture. In October 2025, records showed 2 bed baths and 5 entries marked not available. In November 2025, documentation reflected 4 bed baths, 2 showers, and 2 refusals. In December 2025, the resident received 6 bed baths and 4 showers. In January 2026, the record showed 4 bed baths, 1 shower, and 1 refusal, including documentation of a shower provided on 01/02/2026-prior to the resident reporting to her daughter that she had been taken to the shower and that her arm had been pulled.During an interview with the MDS Coordinator on 02/25/2026 at 2:18 PM, she stated she was unsure why the care plan had been updated to include baths/showers following the reported shoulder fracture. She also stated there was no clinical reason that would prevent the resident from using the shower, even with a history of a hip fracture and despite the family's expressed preference for bed baths.During an interview with the Administrator and Director of Nursing on 02/25/2026 3:25 PM, they stated that Resident #1's injury investigation was closed based on the Nurse Practitioner's (NP) assessment that the fracture was pathological. They explained that the NP reached this conclusion because no tissue damage or inflammation was observed. While the plan of correction following the October fall mandated a two-person assist for bed baths, the facility could not explain why the care plan was edited to allow showers after the January incident. The Administrator verbalized that the family preferred bed baths.During an interview with the Nurse Practitioner on 02/25/2026 at 3:56 PM, he explained that he determined the fracture to be pathological rather than traumatic based on the resident's history of diffuse osteopenia and the absence of visible swelling or bruising. When asked whether he was aware that the family had requested bed baths only and that this was reflected in the care plan, he stated he was not. He also stated he was unsure whether Resident #1 had been taken to the shower. He was informed that documentation showed the resident received a shower on 01/02/2026, that nursing staff had been notified of the resident's arm pain, and that he was contacted after Resident #1's daughter reported pain and noted swelling. When asked if this injury could have been caused by pulling the resident's arm, he stated yes. When asked if he discussed his findings with the radiologist who concluded Resident #1 had an acute fracture, he said no.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations, interviews, and record reviews, the facility failed to implement and maintain accident?prevention interventions for one resident (Resident #1) with a known history of fall?related injury. The facility did not follow the resident's updated care plan requiring two?person assistance for bed baths only, and allowed the resident to be taken to the shower despite this restriction. This failure resulted in the resident sustaining a left humerus fracture and placed her at continued risk for avoidable injury.The findings include:A record review of Resident #1's chart on 02/25/2026 revealed that she had a right closed hip fracture and displaced hip following a fall from the bed on 09/29/2025. The facility reported the following corrective actions after the incident: All bed baths for Resident #1 are now conducted with two person assist.An interview and observation of Employee B, Certfied Nursing Assistant, on 02/25/2026 at 11:19 AM revealed that the facility uses a sticker system outside each resident's door to indicate the required level of assistance, with 1P meaning one?person assist and 2P meaning two?person assist. An observation of the sticker outside Resident #1's room indicated she requires a two?person assist.A sign above Resident #1's bed stating 2?person assist, bed bath only was observed on 02/25/2026 at 11:30 AM. Resident #1's daughter, who was present during the observation, reported that this sign had been in place since the resident's first injury in September 2025. The daughters also stated Resident #1 informed them she sustained an injury while being showered in January. Resident #1 alleged staff pulled on her arm and hurt her.A review of Resident #1's radiology report from 01/05/2026 revealed: Acute left humeral neck fracture.During an interview with Employee D, Licensed Practical Nurse (LPN), on 02/25/2026 at 1:20 PM, she stated that bath preferences should be listed on each resident's care plan.A review of Resident #1's care plan and chart showed that it was updated on 10/02/2025, following the September 2025 injury, to require a two?person assist for bed baths. The care plan was later revised again on 01/07/2026, after the resident sustained a second injury, to indicate a two?person assist for baths/showers. Documentation also showed that the resident had been taken to the shower on 01/02/2026, along with six additional showers documented since September 2025.During an interview on 02/25/2026 at 2:18 PM, the Minimum Data Set (MDS) Coordinator stated she was unsure why the care plan had been modified to include baths/showers after the January fracture. She acknowledged that Resident #1's family preferred two?person assist bed baths but maintained that there was no clinical contraindication that would prevent the resident from receiving a shower.An interview with Employee F, CNA, on 02/25/2026 at 3:13 PM revealed that she recalled assisting another CNA in bringing Resident #1 to the shower in January, prior to the resident's left arm injury.An interview with the Director of Nursing and the Administrator on 02/25/2026 at 3:25 PM confirmed they were aware that Resident #1's family preferred bed baths only with two staff assisting. They were unable to explain the subsequent care plan changes that allowed for baths/showers.