STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105514	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Debary Health and Rehabilitation Center	60 N Hwy 17/92 Debary, FL 32713

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and review of facility's bowel management process, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for three (Resident #1, #2, and Resident #4) of three residents reviewed for management of constipation, by failing to implement medical director's directive/order to administer stool softeners/laxatives. The findings include:1.Review of Resident #1's medical record revealed an admission date of 9/7/23, and a discharge date of 2/2/26. Her diagnoses included unspecified Sequelae of Cerebral Infarction, Cerebral Palsy, generalized anxiety disorder, and constipation, unspecified. Review of Resident #1's quarterly minimum data set assessment dated [DATE], noted the resident had a brief interview for mental status (BIMS) score of 0 out of 15, indicating severe cognitive impairment. The resident was noted as always being incontinent of bowel and bladder.Review of the task for bowel movements for Resident #1 revealed she did not have a recorded bowel movement on 1/24/26, 1/25/26, and 1/26/26 and again on 1/31/26, 2/01/26, and 2/02/26. There was no documented evidence that medications were given for relief to the resident on either occasion. Review of the progress note dated 2/2/26 at 18:30 revealed, family/poa visiting reached out to this nurse, POA stated i need to speak to supervisor asap supervisor immediately notified at this time and spoke to poa/ family. Patient is alert with confusion, just staring at staff when ask, refused dinner, vital signs taken 118/66 pulse 69 resp 19 temp 97.6, poa insist to supervisor to call 911 to send to hospital, supervisor called 911, provider notified to send patient to hospital for altered mental status.Further record review revealed the medical provider ordered a Kidney, Ureter, and Bladder x ray study (KUB) on 2/2/26 with the results reported to be Non-obstructive bowel gas pattern. Abundant fecal burden within the colon. No obvious pneumatosis or free intraperitoneal gas. No acute osseous abnormality.2. On 2/5/26 at 11:15 AM, an interview was conducted with Resident #2. When asked about his care he stated it was ok. When asked if he had ever become constipated, he stated yes and they don't help. Review of Resident #2's medical record revealed an admission date of 5/16/18, with a re-entry date of 1/16/26, with a primary diagnosis of Parkinson's disease with dyskinesia with fluctuations.Review of Resident #2's most recent brief interview for mental status (BIMS) score revealed a 12 out of 15 score, indicating moderate cognitive impairment. Review of the task for bowel movements for Resident #2 revealed he did not have a recorded bowel movement for 1/31/26, 2/1/26, 2/2/26, and 2/3/26. There was no documented evidence that medications were given to the resident per bowel management process.On 2/5/26 at 12:10 PM, an interview was conducted with Employee C, Licensed Practical Nurse (LPN) regarding residents who are constipated. When asked what he would do if a resident were constipated or has a change in bowel habits and what kind of assessment is completed before administering stool softeners or laxatives? He stated there is a red binder at the nurse's station that contains the steps to follow for constipation that he would use. He further stated that he would listen for bowel sounds and document them in the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nurse's notes. On 2/5/26 at 12:30 PM, an interview was conducted with Employee B, Certified Nursing Assistant (CNA). When asked if he lets a nurse know if a resident has a change in bowel movements, he stated that he would let the nurse know. He explained that they had a standard of three days, and it shows up on the resident's electronic chart as well. If he has a resident that has changes that are out of the normal, he will notify the nurse of the changes. 3. On 2/5/26 at 12:45 PM, a review of the electronic chart for Resident #4 was completed for bowel management. The resident was unable to interview.Review of the task for bowel movements for Resident #4 revealed she did not have a recorded bowel movement on 1/23/26, 1/24/26, 1/25/26, 1/29/26, 1/30/26, and 1/31/2026. There was no documented evidence in the medication administration record or progress notes that as needed or when necessary (PRN), medication was given for relief of constipation.On 2/5/26 at 12:50 PM, an interview was conducted with the Assistant Director of Nursing (ADON). When asked how she is notified if a resident was having a problem with constipation, she stated that there is an Icon on upper right corner of electronic chart and would show on the electronic Medication Record (eMAR) as well. The nurse can open it to see what the alert is for. When asked about assessing a resident that has constipation, she stated that they would complete a change in condition form and complete each section in the form. When asked about the protocol she stated she was not aware of one, but residents had standing orders for laxatives and suppositories to use if a resident becomes constipated or goes three days without a bowel movement. During the interview, the Regional Nurse Consultant came into the room. She stated she would check with corporate for a policy or protocol for bowels/constipation. She returned with a bowel management process. She then stated they used this and did not have a policy. Per the protocol, if a resident does not have a bowel movement within 3 days, then they have medications that are to be given. If the resident presents in distress, pain or the interventions are non-effective the provider is to be notified immediately.Review of the facility's Bowel Management process revealed the following: Resident identified as not having a Bowel Movement (BM) in 3 days per the PCC Dashboard will receive the following interventions:*Per our Medical Director, residents without a BM for 3 days receive the designated dose of Milk of Magnesia (30mL every 24 hrs. PRN) and if this intervention has no effect, then a Bisacodyl Supp. 10mg., 1 PR Supp. Every 24 hours PRN to be administered.*If, the resident presents in distress, pain or the interventions are non-effective the provider is to be notified immediately. (Copy obtained)