

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: 105687	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and interview, the facility failed to ensure a properly executed DNR (Do Not Resuscitate) Order for 3 of 3 sampled residents, as evidenced by incomplete yellow copy DNR Order forms for Residents #134, #116, and #62. The findings included: Review of the policy Advance Directives dated [DATE], documented in part, 5. b. Do Not Resuscitate &ndash; Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care DPOA, health care surrogate or health care proxy has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used. Review of the policy Do Not Resuscitate Order dated [DATE], documented in part, 3. Should the resident be transferred to the hospital, a photocopy of the DNRO form must be provided to the EMT personnel transporting the resident to the hospital. 1. Review of the record revealed Resident #134 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact. The record lacked an incapacity form or evidence of a health care surrogate or power of attorney. Review of the record revealed the current code status for Resident #134 was DNR (Do Not Resuscitate). Review of the corresponding yellow copy Do Not Resuscitate Order (DNRO), documenting the resident and or resident representatives' choice for a DNR status, and provided to emergency medical staff upon transfer to the hospital, was incomplete. This form had the printed name of Resident #134 but lacked the resident's signature and the date the resident would have signed the form. 2. Review of the record revealed Resident #116 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented a BIMS score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. Review of the record revealed the current code status for Resident #116 was DNR. Review of the corresponding yellow copy Do Not Resuscitate Order, lacked the resident's date of birth , the date the resident signed the form indicating her wishes, and the resident's printed name. During an interview on [DATE] at 9:48 AM, when asked if she understood her DNR status, Resident #116 stated, Yes, when I stop breathing, I don't want anything done. When asked if she recalled signing the form, the resident stated she did not, and stated she was quite ill upon admission to the facility. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the record revealed Resident #62 was admitted to the facility on [DATE]. Review of the MDS assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 8, on a 0 to 15 scale, indicating the resident had moderate cognitive impairment. The record also showed evidence of a health care surrogate or power of attorney. Review of the record revealed the current code status for Resident #62 was DNR. Review of the corresponding yellow copy of the Do Not Resuscitate Order, which documents the resident and or the resident's representative's choice for a DNR status, and is provided to emergency medical staff upon transfer to the hospital, revealed it was incomplete. This form had the printed names of Resident #62 and the resident's representative but lacked the resident's date of birth and date the resident's representative would have signed the form. During an interview on [DATE] at approximately 12:30 PM, when asked the process for ensuring a resident's code status, specifically regarding a DNR order, Staff D, Licensed Practical Nurse (LPN), explained the facility's process. The LPN stated the nurse or social worker speaks with the resident and or family to ensure understanding of the DNR and obtains the order. When asked if the DNR Order was valid if incomplete, Staff D replied, No, each section has to be completed, signed, and dated for the form to be valid. During a side-by-side review of the records for Residents #62, #116, and #134, Staff D confirmed that the yellow copies of the DNR Orders were missing the residents' date of birth , date the residents' representative signed the form, and or residents' signature.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, record, review and interviews, the facility failed to provide care and services for the treatment and prevention of wounds for 5 of 38 sampled residents as evidenced by failure to follow physician orders for the treatment of a wound for Residents #182 and #36, failure to ensure Resident #184 had treatment for a rash, and failure to complete weekly skin assessments for Residents #182, #27, and #134. The findings included: 1. Record review revealed Resident #182 was admitted to the facility on [DATE]. Review of the comprehensive assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 15 on a 0-15 scale, indicating no cognitive impairment. During an observation on 12/01/25 at 11:09 AM, Resident #182 was observed sitting in his wheelchair wearing shorts and a white square dressing that was undated was noted to his right shin. During an interview on 12/01/25 at 11:09 AM, when asked why about the dressing on the right leg, Resident #182 stated, Well that happened in therapy during a fall. When asked when the last time the dressing was changed, he said, yesterday. When asked how often the dressing is changed He stated, every 2-3 days. Review of a physician order dated 11/21/25 instructed staff to cleanse the skin tear to Resident #182 right shin with normal saline (salt water), apply xeroform (Vaseline gauze) and dry dressing daily on day shift (7AM To 3PM). Review of the November and December 2025 Treatment Administration Record (TAR) revealed that the nurses were documenting that the dressing to Resident's right shin wound was being changed daily. During an observation on 12/03/25 at 9:12 8:48 AM, Resident #182 was observed in bed with a white square dressing, not dated, to his right shin. During an interview on 12/03/25 at 9:12 AM, Resident #182 was asked if his dressing was changed yesterday, he stated, No, but I don't think I need the dressing anymore; the last time they changed it was about two days ago; it was almost healed. They should be changing it again today. During an interview on 12/03/25 at 9:12 AM, when asked if the nurse changed the dressing today, he stated it still needed a dressing. 2. Review of the physician orders dated 11/07/25 instructed staff to perform weekly skin checks on Resident #182 every Friday on the 7 AM-3 PM shift. Review of the skin assessments for Resident #182 revealed documentation of a skin check done only on 11/25/25. Review the November and December 2025 TAR revealed documentation of staff signing that skin checks were done on Resident #182 every Friday as ordered. 3. Record review revealed Resident #184 was admitted to the facility on [DATE]. Review of the comprehensive assessment dated [DATE] documented a BIMS score of 03 on a 0-15 scale, indicating severe cognitive impairment. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/02/25 at 10:18 AM, Staff H was noted in the hallway, As she walked by Resident #184's room, she asked the resident if she was ok and why are you doing this (as she demonstrated the movement of her rubbing the left chest area). The resident said yes, and Staff H continued walking down the hall. During an observation on 12/02/25 at 10:21 AM, Resident #184 was noted sitting on the side her bed scratching the left chest area. During an interview on 12/02/25 at 10:22AM when asked if her skin was itching, Resident #184 stated Yes. She was asked if she had a rash, she did not respond but she pulled her shirt down so her left chest could be seen. It revealed a reddened area with small pimples and scratches to her left chest area. During an interview on 12/03/25 T 9:35 AM when asked if she was still having itchiness to your chest area, Resident #184 showed the area on left chest, and she started to scratch. Her left chest area was noted to have increased redness, tiny pimples and scratches that appeared to be a rash. During an interview on 12/03/25 at 9:44 AM, Staff H was asked to go with surveyor to Resident #184's room. At this time, she was made aware that the resident was observed over the past two days scratching her left chest area. She stated, I noticed her doing that yesterday. She was made aware that she was overheard on Monday asking the resident, from the hallway, if she was ok, as she saw the resident rubbing her chest area, but she did not go into her room. Staff H asked the resident if she could look at her chest, as she applied a pair of gloves. The resident pulled down her gown, Staff H assessed her chest area and stated, Oh my, I will take care of it. Review of the physician orders for Resident #184, did not reveal any new orders for a rash. During an interview on 12/04/25 at 8:58 AM, when asked did they obtained medication for the itchy area on your chest, Resident #184 shook her head and said, she began to show the rash by pulling down her gown and it was noted that the redness, pimples and scratches were also now on the right and left side of her chest. During an interview on 12/04/25 at 9:02AM when asked if she received report regarding a skin issue for Resident #184, Staff I, License Practical Nurse, looked at her notes and stated No. During an observation on 12/04/25 at 9:08 AM, Staff I was observed assessing Resident #184's chest area. She stated Yes I see. It looks like a pattern, both areas are circular. She asked the resident if it was itchy and she said a little bit. Staff I stated, I will notify the doctor. During an interview on 12/04/202 at 9:10 AM, Staff I stated, I just wanted to let you know that I notified the doctor and I'm waiting for a response. Review of the physician orders revealed a new order for Resident #184 dated 12/04/25 instructed staff to apply triamcinolone acetonide cream (steroid cream for inflammation, itching) topically to chest daily for 10 days. 4. The facility's policy, 'Dressings, Dry/Clean' with a reference date of 12/10/24 documented: Steps in the procedure: 17. Apply the ordered dressing and secure with tape or bordered dressing per (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order. Label with date and initials to top of dressing. Record review documented Resident #36 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly MDS with a reference date of 11/03/25, Resident #36 had a BIMS score of 09, indicating the resident had moderate cognitive impairment. Resident #36's diagnoses at the time of the assessment included: Anemia, Hypertension, Hyperlipidemia, Aphasia, Non-Alzheimer's dementia, Seizure disorder, Malnutrition, Anxiety disorder, Depression, Encephalopathy, Hypokalemia, Opioid dependence, and Chronic pain. Resident #36's physician's orders included: Skin prep right elbow intact blood blister with skin prep daily and cover with foam dressing daily & 11/17/25. During an interview, on 12/02/25 at 10:28 AM with Resident #36, it was noted that the resident had a wound dressing on the right arm near the elbow that was not dated. When asked about the wound. Resident #36 stated that the dressing was changed every day and that it was for a blood blister that had opened after a fall. During an interview, on 12/04/25 at 10:16 AM, with the Risk Manager / Wound Care Nurse, when asked about providing dressing changes to the wound, the Wound care Nurse replied, I do rounds with the provider, the nurses on the unit are being done by the nurses on the floor and they report the Unit Manager on the units - care was provided by nurse on shift that day. During an interview, on 12/04/25 at 10:31 AM, with Staff A, Registered Nurse, when asked about Resident #36's wound, Staff A replied, she had knocked her arm on the handle of the closet on 11/13/25 and it became a fluid filled blister. The last time I saw it, it was flat (12/01/25 at about 11:30 AM). The RN was shown the photographic evidence of the dressing that was obtained and acknowledged that she was the one who provided the dressing and acknowledged that the dressing should have been dated and was not. 5. Review of the record revealed Resident #27 was admitted to the facility on [DATE] with diagnoses to include dementia. Review of the MDS assessment dated [DATE] documented the resident had a BIMS score of 3, on a 0 to 15 scale, indicating the resident was severely cognitively impaired. This MDS also documented that the resident was at risk for pressure injuries. Review of the current care plan initiated on 02/26/24 and reviewed and or revised on 11/13/25 documented Resident #27 was at risk for skin alterations with an approach for the nursing staff to complete weekly skin checks. Review of current physician orders documented as of 03/29/24 staff were to complete weekly skin checks every Thursday on the 3 PM to 11 PM shift. The orders also instructed as of 08/06/25, staff were to apply a zinc oxide barrier cream to the resident's buttock for preventative measures. Further review of the record revealed the most current weekly skin check was completed on 11/21/25, and lacked a skin check the week of 11/23/25 through 11/29/25. 6. Review of the record revealed Resident #134 was admitted to the facility on [DATE]. Review of the current MDS dated [DATE] documented that the resident had a BIMS score of 10, on a 0 to 15 scale, indicating moderate cognitive impairment. This MDS also documented the resident had a current unhealed pressure injury and was at risk for further pressure injuries. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the current care plan initiated on 06/08/25 and reviewed and or revised on 12/01/25 documented Resident #134 was at risk for further skin alteration, and had moisture associated dermatitis as of 10/26/25. One of the approaches was for the nursing staff to complete weekly skin checks. Current physician orders included the weekly skin checks as of 06/16/25 and a protective ointment to the buttock. Further review of the record revealed the most current weekly skin check was completed on 11/21/25, and lacked a skin check the week of 11/23/25 through 11/29/25. During an interview on 12/04/25 at 11:01 AM, when asked how staff knew when a resident's weekly skin check was due to be completed, the Assistant Director of Nursing (ADON) explained that each unit had a schedule, an order was placed in the resident's medical record, and the nurses were expected to sign off the completion of the skin check in the Medication Administration Record (MAR) and complete the documented observation form. The ADON confirmed the weekly skin checks for Residents #27 and #134 were signed off as completed on the respective MARs, but the skin checks were not completed as the observation forms had not been done.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and positioning equipment for 2 of 3 sampled residents as evidenced by failure to provide properly fitting wheelchair leg rests for Resident #118 and failure to provide a hand/towel roll for hand contractures to Resident #12. The findings included: 1. Review of clinical record revealed Resident #118 was admitted to the facility on [DATE] with a primary diagnosis of Cerebral Infarction. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #118 had a Brief Interview for Mental Status (BIMS) score of 13 on a 0-15 scale, indicating the resident had intact cognition. During an initial interview on 12/01/25 at 11:20 AM, Resident #118 stated that he would like to go to activities but cannot go since his knees do not bend anymore and sitting in the wheelchair causes his legs to hurt. Resident #118 stated that he thinks he is worse now than when he got here. Resident #118 was asked how long it had been since he was in his wheelchair and he replied, at least 2-3 weeks ago. Resident #118 was then asked who he had told about the issue with his legs and the wheelchair to which he replied, 'everyone knows'. Review of the care plan dated 08/25/25 revealed that Resident #118 was interested in participating in his own leisure time activities (watching TV, people watching in the hallway, visiting family, and socializing with staff and resting). He had decreased mobility, secondary to a diagnosis of foot drop, cerebral infarction with bilateral hemiplegia as evidenced by Resident #118 requiring partial/moderate assistance with bed mobility, transfers, dependent with wheelchair, is non-ambulatory. Review of the Physical Therapy Evaluation dated 04/01/25, in part, in the section Musculoskeletal Assessment Contractures revealed Resident #118 did not have any functional limitations present due to contractures and that Lower Extremity Range of Motion was listed as Within Functional Limits (WFL) for both the Right and Left Lower Extremities. Review of the Physical Therapy Discharge summary dated [DATE], in part, revealed Resident #118 required partial / moderate assistance with bed mobility, partial / moderate assistance with transfers, and walked 10 feet with partial / moderate assistance. Review of Occupational Therapy Discharge Summary, in part, revealed Resident #118 required supervision / touch assistance to self-propel a wheelchair and make two turns throughout the nursing facility. Review of the Physical Therapy and Occupational Therapy Evaluations that were completed on 12/03/25, revealed that Resident #118 required substantial / maximal assistance for bed mobility, was dependent on transfers, could not attempt walking, and was able to sit up in wheelchair for 90 minutes. Resident #118's wheelchair was listed as a reclining wheelchair with adaptive equipment / devices of elevating leg rests, head rest, calf pad or other positioning devices to accommodate bilateral lower extremity contractures. In the PT/OT evaluation of 12/03/25, the Musculoskeletal Assessment revealed Resident #118 had impaired Range of Motion (ROM) to both lower extremities (hips, knees and ankles) and had functional limitations present due to contractures to bilateral hips, knees and ankles. An interview was conducted on 12/03/25 at 11:00 AM with Staff E, Licensed Practical Nurse (LPN), who stated he knows Resident #118 well. When Staff E was asked if Resident #118 gets up in his (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair, he stated that Resident #118 usually refuses to get up in the wheelchair and that Resident #118 complains of pain in his legs while in bed. Staff E was asked how often Resident #118 gets up in his wheelchair and he stated only for doctors' appointments. Staff E stated that Resident #118 had family visit the day after Thanksgiving and Resident #118's family wanted to bring him outside but Resident #118 refused to get up in the wheelchair but never said why he did not want to get in the wheelchair. An interview was conducted with Staff F, LPN, on 12/03/25 at 11:05 AM who also works on the unit and knows Resident #118. Staff F stated that whenever Resident #118 was in his wheelchair he complained of pain and would request to go back to bed. When Staff F was asked if she knew why he is in pain in the wheelchair she replied, No, he never said why he just asked to go back to bed. Staff F was then asked how often Resident #118 gets up in his wheelchair and she replied, only for doctor's appointments. Staff F was asked when Resident #118 had his last doctor's appointment, she replied he had a cardiologist appointment on 10/06/25. An interview was conducted with Resident #118 on 12/03/25 at 11:17 AM and he was advised that his last doctor's appointment out of the building was on 10/06/25, and he was asked if he remembered how he felt in the wheelchair at that time and Resident #118 replied, it hurt to be in the wheelchair and I was in pain. Resident #118 was asked if he told staff that it was the wheelchair that was causing him to have leg pain and he stated that he had told staff that his legs hurt when sitting in the wheelchair. An interview was conducted on 12/03/25 at 11:28 AM with Staff G, LPN / Unit Manager, who stated that Resident #118 was refusing to get up in the wheelchair, and we think it is because he has a fear of falling. Staff G was asked if Resident #118 had a standard wheelchair or any adaptive wheelchair parts to which she replied, I think he has something to support his legs like a buddy board/calf board. An interview was conducted on 12/03/25 at 11:35 AM with the Rehabilitation Director, who stated that she is an Occupational Therapist (OT) and has worked with Resident #118 in the past. The Rehabilitation Director was asked if Resident #118 had any special adaptations to his wheelchair or if she had been advised that he does not want to get out of bed and she stated that in her knowledge of Resident #118, he does not want to get out of bed and that there were not any orders for adaptive equipment for his wheelchair, but that she would go to his room and check his wheelchair. On 12/03/25 at 12:04 PM the Rehabilitation Director stated that she had just met with Resident #118 and assessed his current wheelchair and he had standard (non-elevating) legs rests on the wheelchair and that Resident #118 advised her that his knees do not bend enough to use that type of leg rest and he agreed to get up in the wheelchair if it had leg rests that would support his legs. The Rehabilitation Director stated that staff would transfer Resident #118 to his wheelchair after lunch and she would work with him on positioning in the wheelchair. On 12/03/25 at 2:01 PM, Staff E stated that they had just tried to transfer Resident #118 from his bed to the wheelchair using a mechanical lift (Hoyer) and Resident #118 was in too much pain to continue the transfer since his knees were bending when he was in the sling. Staff had to lower Resident #118 back to bed. On 12/03/25 at 2:07 PM, the Rehabilitation Director was notified by the surveyor that Resident #118 had to be put back to bed since he was unable to tolerate the Hoyer lift transfer from his bed to the wheelchair. The Rehabilitation Director was asked how she should have found out about Resident (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#118's decline in his ability to bend his knees and tolerate sitting in the wheelchair. She stated either through a Therapy Quarterly Screening or through a nursing request for a Therapy screening. Observations on 12/03/25 at 2:23 PM revealed Staff E, Certified Nursing Assistant (CNA), and the Rehabilitation Director were able to transfer Resident #118 to the wheelchair. When he passed the surveyor on his way to the therapy gym in his wheelchair, he was in a wheelchair with a reclining back and elevating leg rests (keeping his knees straight out instead of bent) and a pillow under his legs. Observations on 12/03/25 at 3:23 PM revealed Resident #118 was in the therapy gym sitting upright in his wheelchair and stated that he was happy to be out of bed. The Rehabilitation Director stated that Resident #118 was able to self-propel the wheelchair around the gym today and that Physical Therapy had done an Evaluation to initiate Physical Therapy services. The Rehabilitation Director stated that Occupational Therapy had completed Quarterly Screening on Resident #118 on 10/02/25 with documented results that Resident #118 presented with a decline in functional transfers and that Physical Therapy or Occupational Therapy would conduct an evaluation. An interview was conducted on 12/04/25 at 9:54 AM with Resident #118 who was asked if he had expressed fear of falling to staff and he stated that he was nervous about pain having to do with his knees, hips and ankles and not about falling. An interview was conducted on 12/04/25 at 2:55 PM with the Rehabilitation Director who was asked why Resident #118 was not evaluated after the Quarterly Therapy Screening on 10/02/25 and she stated that from what she can recall, therapy staff had asked Resident #118 to transfer to his wheelchair and go to therapy a few times after the screening and Resident #118 refused to get out of bed but that she did not have any documentation of the refusals. An interview was conducted with Resident #118 on 12/04/25 at 3:05 PM to see if he remembered being screened by someone from Occupational Therapy and if he refused to be evaluated by therapy and he replied, 'No. I do not remember that, I may have refused to get up in that wheelchair but I would've gladly started therapy if they could've helped me, I want to get out of here and go home. 2. Record review revealed Resident #12 was readmitted to the facility on [DATE]. Review of the annual assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 04 on a 0-15 scale, indicating severe cognitive impairment. Review of the medical diagnosis documented a history of CVA (stroke) with Left Hemiparesis (left side paralysis). During an observation on 12/01/2025 at 10:26 AM Resident #12 was in her room sitting in her low chair, and her hands were noted to be contracted. No splints or brace was noted to her hands. Review of the care plan dated 11/02/25 documented Resident #12 had a problem with ADL [Activities of Daily Living] / Mobility, self-care deficit related to Dx [diagnosis] of CVA with (L) [left] Hemiparesis, Aphasia, Seizures, Hypothyroidism, Subdural Hematoma (Hx) [History], Abnormal Gait, Alzheimer's Disease, Muscle Weakness as evidenced by she required total dependence with wheel-chair mobility / non-ambulatory / dependence in bed mobility/transfers x2 / substantial / max with meals dependent /oral hygiene / dressing / bathing / showers / personal grooming, with a goal that Resident #12 will feed herself with substantial / max assist from staff and one of the approaches included to provide a rolled wash cloth in her right hand and to remove it for hygiene and skin observation. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Solaris Healthcare Parkway		STREET ADDRESS, CITY, STATE, ZIP CODE 800 SE Central Pkwy Stuart, FL 34994	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a physician order dated 07/09/2024 instructed staff to place a rolled-up wash cloth in Resident #12's right hand once a day at 0900 AM. During an observation on 12/02/25 at 12:42 PM, Resident #12 was observed in her room sitting in her chair, no splint or rolled towel was noted to her right hand. The resident's bilateral hands were contracted. During an observation on 12/03/25 at 9:28 AM, Resident #12 was observed in the hallway sitting in her chair, bilateral hands contracted a hand splint or towel was not noted to her right hand. Review of the December 2025 Medication Administration Record (MAR) revealed documentation that Staff H had signed on 12/01/25 and 12/03/25, indicating that she had applied the rolled towel to Resident #12's right hand. During an interview on 12/03/25 at 9:40 AM, when asked does Resident #12 wear a splint or device to her hands for the contractures. Staff H, Registered Nurse (RN) stated Yes, she has a wrist guard that she is supposed to wear as tolerated but she has behavior issues, so she refuses it. When Staff H was asked if she had tried to put on the wrist guard, she stated, No, we will try. During a follow-up interview on 12/03/25 at 9:45 AM, Staff H stated, I'm sorry, but Resident #12 does not wear a wrist guard, it's a rolled towel, I float so, I didn't know. When she was asked if she had been on this unit for the past few days, Staff H stated, Yes, but I'm everywhere.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to assess residents for safe smoking for 2 of 3 sampled residents reviewed for smoking, Residents #38 and #170. The findings included: Review of the facility's policy, titled, 'Smoking Policy' with a reference date of 01/07/22, documented, in part: 'Procedure: 3. A smoking assessment will be completed upon admission, quarterly during care plan review, and upon a change in resident condition 1. Record review revealed Resident #38 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS) with a reference date of 09/03/25, Resident #38 had a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Resident #38's diagnoses at the time of the assessment included: Heart failure, Hypertension, DM, Hyponatremia, anxiety disorder, Depression, Chronic lung disease, Respiratory failure, Muscle weakness, Chronic pain, and Bronchiectasis. Review of Resident #38's care plan for Nicotine use, with a start date of 12/11/24 documented, 11/12/25 noted coming from smoking patio wearing oxygen. The goal of the care plan was documented as, Patient/resident will demonstrate safe smoking practice thru target date: 12/10/25. Interventions in the care plan included: Complete smoking assessment upon admission and quarterly and as needed - 12/11/24. A Smoking Data Collection and Assessment, with a reference date of 03/05/25, concluded that the resident was able to smoke safely without supervision. Further review of the resident's electronic health records revealed no additional assessments being completed at least quarterly and upon being observed coming from the smoking patio wearing oxygen on 11/12/25. 2. Record review revealed Resident #170 was admitted to the facility on [DATE] and most recently readmitted on [DATE]. According to the resident's most recent complete assessment, an Annual MDS with a reference date of 10/03/25, Resident #170 had a BIMS score of 11, indicating the resident was moderately cognitively impaired. Resident #170's diagnoses at the time of the assessment included: Anemia, Atrial fibrillation, Gastro-esophageal Reflux disease (GERD), Coronary Artery Disease (CAD), Heart failure, Hypertension, Diabetes Mellitus, Alzheimer' disease, Non-Alzheimer's dementia, Anxiety disorder, Depression, Chronic lung disease, and Respiratory failure. Review of Resident #170's care plan for nicotine use, with a reference date of 10/14/24, documented, 01/20/25 noted smoking in room. Educated on dangers of smoking inside of the building. The goal of the care plan was documented as, Patient/resident will demonstrate safe smoking practice thru target date 01/09/26. An intervention to the care plan included: Complete smoking assessment upon admission and quarterly and as needed - 10/14/24. A Smoking Data Collection and Assessment, with a reference date of 04/01/25, concluded that the resident was able to smoke safely without supervision. Further review of the resident's electronic health records revealed no additional assessments being completed at least quarterly. During an interview on 12/04/25 at 11:38 AM with the Assistant Director of Nursing (ADON) and Staff B, RN/Unit Manager, when asked about completing the smoking assessments for the residents, the RN/UM replied, I am responsible for my units. The Unit Managers are responsible for their units. When asked about assessments being completed for Residents #38 and #170, the RN/UM replied, He moved to me later that year (referring to Resident #38). The ADON replied, they were missed.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview, and record review, the facility failed to ensure appropriate care and services for oxygen use for 1 of 3 sampled residents as evidenced by the lack of oxygen order and oxygen saturation assessment for Resident #124. The findings included: Review of the policy Oxygen Administration dated January 2020, documented in part, 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review of the record showed Resident #124 was admitted on [DATE] with a diagnosis including Heart Failure. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 4, on a 0 to 15 scale, indicating severe cognitive impairment. Review of the progress noted dated 10/18/25, revealed the resident had a productive cough and wheezing for which a chest X-ray was ordered. Based on the results, the resident was diagnosed with Pneumonia. Review of a progress note dated 10/20/25 documented the resident's oxygen saturation was in the 70%s and that the resident was prescribed and administered 2 liters of oxygen (O2) to be delivered by nasal cannula (NC) as well as breathing treatments. Further record review revealed that on 10/22/25, 10/24/25, 10/27/25 and 10/31/25, entries were made by the Infectious Disease physician that upon evaluation, Resident #124 was on 2L O2 via NC. There was no corresponding order for oxygen administration with the amount to administer. Top of Form Record review also revealed a lack of oxygen saturation levels for the dates the resident was documented to be on oxygen therapy. On observation on 12/01/25 at 10:02 AM, Resident #124 was resting in bed, pleasantly confused with O2 at 2L via nasal cannula. Review of the current orders also lacked any for the administration of oxygen. During an interview on 12/04/25 at 11:30 AM, the Assistant Director of Nursing (ADON) was asked to locate and provide an order for the use of oxygen currently and in October 2025. The ADON confirmed there was none.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on competency review, observation, and interview, the facility failed to ensure infection control practices during the medication pass observation with 1 of 6 licensed nurses (Staff C, Licensed Practical Nurse), as evidenced by the failure to dispose of gloves after use, failure to ensure hand hygiene with glove use, failure to properly disinfect a glucometer (device that measures the resident's blood sugar level), and failure to properly dispose of the used lancet. The medication pass observation was for Resident #38. The findings included: Review of the facility's competency for blood glucose monitoring revealed the following steps: 1. Perform hand hygiene before completing blood glucose testing or disinfecting. 2. Put on single-use gloves prior to blood glucose testing or disinfecting. 12. Dispose of lancet in biohazardous waste sharps container. 14. Clean the glucometer after each use, using the approved bleach disinfectant wipe and ensure all external surfaces of the glucometer remain wet for a period of no less than 3 minute, or contact time designated by manufacturer by wiping both the front and back of the glucometer, wrapping the approved bleach disinfectant wipe around the glucometer and keeping it wrapped for 3 minutes. 17. Remove and dispose of used single-use gloves. 18 Perform hand hygiene after completing blood glucose testing or disinfecting. Review of the manufacturer's instructions for the blood glucose device documented the use of disinfectants to include Medline Micro-Kill Bleach Germicidal Bleach Wipes. The instructions did not include the use of Micro-Kill Two Germicidal Wipes. A medication pass observation was completed on 12/03/25 beginning at 3:48 PM with Staff C, Licensed Practical Nurse (LPN), for Resident #38. The LPN gathered supplies for the blood sugar monitoring on a disposable tray, to include the canister of strips, one lancet, and an alcohol wipe. The glucometer was wrapped in a tissue on top of the medication cart upon arrival by the surveyor. The LPN donned a pair of gloves while standing at the medication cart, locked the cart, and proceeded down the hall, two rooms down, to the room of Resident #38. The LPN obtained the resident's blood sugar level, and walked back to the medication cart, still wearing her used gloves. The LPN entered information into the computer with her gloved hands, threw the lancet into the Sharps container, but did not ensure the lancet fell into the container, then removed her gloves inside-out and placed them on top of the cart. The LPN opened the medication cart and obtained a Micro-Kill Two Germicidal wipe. She then wiped the glucometer, and immediately wrapped it in a dry tissue and stated, Is this OK?. Staff C, LPN proceeded to assist two residents and failed to do any hand hygiene during the blood sugar check or after assisting either resident. The LPN stated she was going to give Resident #38 Tylenol for his headache. The LPN donned a pair of gloves, obtained the Tylenol, locked the medication cart, and gave the Tylenol to Resident #38. The LPN returned to the medication cart wearing the same gloves. The LPN removed her gloves and confirmed she was done, as she placed the canister of strips and glucometer back into the cart. The LPN did not do any type of hand hygiene. During the continued observation and interview, when shown the lancet on top of the sharps' container, the LPN stated, Oh and engaged the top to allow the lancet to fall into the secured section of the container. The LPN was asked to provide the canister of disinfectant wipes which documented a two-minute contact time. When asked what that meant, the LPN stated she needed to wipe the glucometer for two minutes and let it dry for two minutes. When asked if wrapping the glucometer in a dry tissue allowed for a two-minute wet contact time, the LPN stated, No. When asked if applying gloves at the medication cart, walking down the hall, and returning to the medication cart wearing gloves after having cared for a resident was appropriate, the LPN stated, That's the way I always do it. The Director of Nursing (DON) was made aware of the above observation on 12/03/25 at approximately 4:45 PM and agreed with the findings. During an interview on 12/04/25 at 2:46 PM, when asked to confirm which disinfectant wipe was used for the glucometers, the Infection Control Preventionist (ICP) confirmed the use of the Micro-Kill Bleach wipes as per manufacturer's instructions. When asked about taking the canister of glucometer strips into a resident's room, the ICP stated the expectation was that the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse would take just one strip into the resident's room and the canister would stay in the medication cart.		