STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106091	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxe at Wellington Rehabilitation Center The	10330 Nuvista Avenue Wellington, FL 33414

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 - 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, interview, and record review, the facility failed to ensure appropriate and timely care and services for 3 of 24 sampled residents as evidenced by the failure to coordinate care with a consultant physician to ensure continued administration of antibiotics for Resident #4; failure to ensure care for a skin tear to the left lower extremity of Resident #116; and failure to ensure documented blood pressure readings at the time of administration of an antihypertensive (blood pressure) medication with physician ordered parameters for Resident #116; and failure to follow physician ordered parameters for antihypertensive medications for Resident #127.The findings included:1) Review of the record revealed Resident #4 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS documented the resident was on an intravenous (IV) antibiotic medication. Review of the current physician order revealed as of 03/09/26 Resident #4 was to receive Daptomycin (an antibiotic) via IV once daily until 03/19/26. Previous physician orders revealed the resident received the Daptomycin from 02/07/26 through 03/05/26. The record lacked any evidence of antibiotic administration or reason for the lack of administration on 03/06/26, 03/07/26, and 03/08/26. A progress note dated 03/03/26 confirmed Resident #4 went to the infectious disease (ID) physician that day. A physician's order from the ID physician dated 03/03/26 documented the resident was to continue the IV Daptomycin until 03/16/26. During an interview on 03/10/26 at 11:35 AM, Resident #4 explained she had gone to the ID physician last Tuesday (03/03/26), had received written orders to extend the antibiotics for two weeks. Resident #4 stated she took a photo of the order and handed it to the nurse upon return from the consultant physician's office. Resident #4 stated by Friday morning (03/06/26), she was not getting the antibiotic. The resident stated she spoke with a supervisor on that Friday and told her the issue. The supervisor responded she would take care of it, but never heard from her or anyone else again. Resident #4 stated she went through the weekend and Monday without the antibiotics for her MRSA (Methicillin Resistant Staph Aureus, an infection that was difficult to treat), of her left hip wound, and they finally got the antibiotics restarted Monday evening. During an interview on 03/12/26 at 10:43 AM, when asked about the process for new orders when a resident goes out to a consultant physician appointment, Staff B, Licensed Practical Nurse (LPN)/Unit Manager, explained when the resident returns from the appointment, they give the new order to a nurse. The Unit Manager stated if the resident does not provide an order, the nurse is to ask (continued on next page)

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 - Few	the residents if they received one, and if not, they are to document the lack of an order in the medical record. When asked what happened to Resident #4's antibiotics on 03/06/26 through 03/08/26, the Unit Manager stated she was unaware of any issue. When told of the consultant's physician order to continue the IV daptomycin and that it did not get put into place upon return from the office visit, the Unit Manager had no explanation but agreed with the findings. 2) Review of the record revealed Resident #116 was admitted to the facility on [DATE]. Review of the initial nursing assessment from 02/28/26 lacked any skin issues to the resident's left leg. Review of the weekly skin assessment on 03/03/26 documented the resident had a skin tear to his left lower leg after having sustained a fall on that same day. The weekly skin checks for 03/04/26 and 03/11/26 lacked any mention of the skin tear. Review of physician orders lacked any order for care to the resident's left leg. During an observation and interview on 03/09/26 at 10:01 AM, a large (approximately 4 inches by 6 inches) white wound dressing, that was curled up along the edges and had a faded date of 03/03/26 along the edge was noted to the resident's left leg. Upon observation a bloody-like area about 2 inches in diameter was seen through the dressing. When asked how long the dressing had been on his leg, the resident stated, about a week or so. Photographic evidence obtained. During the medication pass observation with Staff K, Registered Nurse (RN), on 03/10/26 at 9:45 AM, the same wound dressing was noted to the resident's left leg. During an observation on 03/11/26 at 4:09 PM, the same wound dressing remained on the resident's left leg. When shown to Staff B, LPN/Unit Manager, she agreed with the findings. 3) Review of the record revealed Resident #116 was admitted to the facility on [DATE] with diagnosis to include essential hypertension. Review of the physician orders revealed as of 02/28/26 Resident #116 was to receive the medication Metoprolol 50 mg (milligrams) twice daily at 9 AM and 5 PM, but to hold the medication for a systolic blood pressure less than 100 (the top number of the blood pressure reading) or a heart rate less than 60 beats per minute. Review of the corresponding Medication Administration Record (MAR) for March 2026 lacked any documented blood pressure or heart rate readings with the medication. During a medication pass observation for Resident #116 on 03/10/26 at 9:19 AM, Staff K, Registered Nurse (RN) held the resident's Metoprolol because the blood pressure reading was 99/64. Review of the MAR documented a blood pressure reading of 112/58, clearly not taken at the time of the medication pass observation. Further review of the MAR documented daily vital sign reading for the day shift (7 AM to 7 PM) and the night shift (7 PM to 7 AM). This entry lacked any specific time for the vitals, thus there was no way to know if the blood pressures and heart rates were taken with the medication. This documentation also lacked two entries on the day shift to incorporate both doses of medications on that shift. Review of the vital sign summary documentation lacked any vitals at 5 PM for 9 of 11 days. During a side-by-side review of the record and interview on 03/12/26 at 10:43 AM, Staff B, Unit Manager, agreed with the lack of documented blood pressure and heart rates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) Review of the electronic records for Resident #127 revealed that he was admitted to the facility on [DATE] with a readmission from the hospital on [DATE] and 12/24/25. His diagnosis included Chronic Diastolic Heart Failure, Type II Diabetes, Dementia, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease (COPD), Generalized Muscle Weakness and Malignant Neoplasm of the Bronchus or Lung. Further review of the physician's order revealed he had an order for Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG, to give 1 tablet by mouth two times a day for hypertension Hold for systolic blood pressure (SBP) less than 100 or Diastolic blood pressure (DBP) less than 60 or heart rate (HR) less than 60 start. The start date was 08/18/25 and the end date 09/15/25. Further review of this medication on the Medication Administration (MAR) revealed the following dates this medication was given and should have been held per the physician parameters. On 08/21/25 the 09:00 AM dose of Metoprolol, the blood pressure was 106/58. The diastolic of 58 is below the parameters of 60 and should have been held. A checkmark with no code documented it was given. On 08/22/25 the 09:00 AM dose of Metoprolol, the blood pressure was 102/53. The diastolic of 53 is below the parameters of 60 and should have been held. A checkmark with no code documented it was given. On 08/22/25 the 05:00 PM dose of Metoprolol, the blood pressure was 111/52. The diastolic of 52 is below the parameters of 60 and should have been held. A checkmark with no code documented it was given. On 08/23/25 the 09:00 AM dose of Metoprolol, the blood pressure was 110/54. The diastolic of 54 is below the parameters of 60 and should have been held. A checkmark with no code documented it was given. On 08/23/25 the 05:00 PM dose of Metoprolol, the blood pressure was 119/58. The diastolic of 58 is below the parameters of 60 and should have been held. A checkmark with no code documented it was given. On 08/25/25 the 09:00 AM dose of Metoprolol, the blood pressure was 127/58. The diastolic of 58 is below the parameters of 60 and should have been held. A checkmark with no code documented it was given. On 08/25/25 the 05:00 PM dose of Metoprolol, the blood pressure was 105/51. The diastolic of 51 is below the parameters of 60 and should have been held. A checkmark with no code documented it was given. On 08/27/25 the 09:00 AM dose of Metoprolol, the blood pressure was 101/50. The diastolic of 50 is below the parameters of 60 and should have been held. A checkmark with no code documented it was given. During an interview on 03/12/2026 at 10:15 AM with the Director of Nursing (DON), he reviewed the MAR (Medication Administration Record) for 08/25 and acknowledged the findings. During an interview on 03/12/26 at 1:02 PM Staff H, LPN (Licensed Practical Nurse) She reviewed (continued on next page)

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