Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	94303	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS An unannounced Licensure complaint survey, complaint number 2025004445, was conducted on and concluded on at Stuart Rehabilitation And Healthcare. The facility had deficiencies at the time of the survey.	N 000		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined, the facility failed to appropriately assess 1 of 2 sampled residents experiencing changes in condition, Resident #1, as evidenced by the lack of monitoring signs and symptoms of a obstruction, that included , , / , and . The findings included: Clinical record review conducted on revealed Resident #1 has been a long-term care resident at the facility since . Review of the Minimum Data Set (MDS) quarterly assessment, with reference date , documents Resident #1 was assessed as severely , for skills of daily decision making; is always of and	N 201	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	94303	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 1 ; has active diagnoses of ; and is dependent on staff for activities of daily living (ADLs). Revie of the Care plan titled, At risk for , related to decrease self-mobility, last revised , documents interventions as: "observe for and report to medical doctor complications related to , : change in mental status, new onset , sleepiness, inability to maintain posture, agitation, , , distension, , small loose stools, fecal smearing, decreased sounds, diaphoresis, tenderness, guarding, rigidity and fecal compaction." The electronic record revealed a nurse's note communicating to the physician via fax dated . The nurse advised the physician that Resident #1 was , and the nurse requested medication. The physician replied with an order for 4 milligrams every six hours as needed. Review of the Progress notes dated documents, "Resident remains in bed at this time and will not allow staff to get her up. Resident did not eat breakfast this morning and would not allow staff to feed her. Vital signs stable. Resident fought this nurse when the , cuff was applied but ultimately allowed vitals to be obtained. . Resident continues to sleep but is responsive and easily roused." Review of the Advance Practitioner Registered Nurse (APRN) notes dated documents, "Seen in bed , , vital signs stable. Patient not eating, won't get out of bed which is not her norm. Patient did one episode yesterday."	N 201	The resident (Resident #1) was sent to the hospital for evaluation and treatment. The family declined surgical intervention and the resident was placed on Hospice services. A medication error was completed for the omission of the medication ordered on . The nurse completed an online Medication Error Prevention course on , . How will you identify other residents having potential to be affected by the same deficient practice. An audit was completed on to ensure that no other residents had an unidentified change in condition. No other residents were identified. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur. Licensed nursing staff were educated on for the need to complete a Change in Condition Observation in the Electronic Medical Record and to continue monitoring the resident for a minimum of 72 hours which will include vital signs, change in condition progress notes each shift, and notification & updates to the physician and family.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	94303	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 2 Review of the APRN notes dated documents, the resident "was seen in the hallway, , has resolved, , and tests were negative. The resident refused fluids and laboratory studies." Review of the Progress notes dated documents as follows: "Resident noted to be choking while swallowing thin liquids. APRN notified and new orders for speech consult." "APRN notified of resident's abdomen is distended and causing her discomfort. New orders to give a and a KUB (, , , and) stat." "APRN was notified of resident produced a large post ." "APRN was notified of KUB results." Review of the x-rays results dated documents, "mild to moderate ileus, follow up , is needed." Review of the vital signs report and progress notes indicated the last documented vital signs for Resident #1 were dated . Review of the Progress notes dated documents the resident "noted with no sounds in any quadrant. Emergency services were called to send the resident out. APRN aware. Family notified." The record failed to document Resident#1's condition or vital signs prior to transfer. Review of the Hospital records indicate Resident #1 arrived at the emergency department via	N 201	Nurses have also been educated that they must notify the physician by phone when they initiate a Change in Condition Observation. The Nurses have been re-educated that all physician orders must be entered into the electronic medical record under Orders upon receipt of a new physicians order. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The DON or designee will monitor the Change of Condition Observations initiated by a notification in the Messages tab of the Electronic Medical Record on a daily basis . The DON or designee will schedule a change of condition progress note for every shift for the next 72 hours after the initial Change of Condition Observation has been completed. The DON or designee will audit all Change of Condition Observations twice a week for completion and follow up. Findings will be reported monthly to the QAPI committee for a period of 3 months and or until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	94303	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 3 ambulance, with complaints of and distention for two days. Rescue states, as per nursing staff, the patient had ileus found two days ago. The patient has and is oriented to person. The record indicates the resident arrived with unstable vital signs, , , , level 90 percent on room air. Laboratory studies indicate increased count, decreased , levels, and abnormal , function. of the abdomen revealed the following: 1. , with severe fecal impaction that extends out through the to the upper abdomen. The measures 11 cm in diameter and the measures 12 cm in diameter and is distended with dense appearing , extends through the splenic flexure. There is wall thickening of the descending , and likely reflecting stercoral . 2. , . Large amount of , , from , likely related to the severe fecal impaction/stercoral . Recommend General Surgery consultation. The emergency department notes documents, "Patient with , signs on exam. Lab studies consistent with , . Discussed with general surgery. Awaiting imaging. ...After imaging patient with , , in the setting of severe , and would require , ... Plan for hospice care with [Name provided] hospice. Patient to be admitted." An interview was conducted with the Director of Nursing (DON) on at 12:34 PM who revealed the facility reviewed the care provided to Resident #1 after she learned the resident had a obstruction and the staff reviewed the	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	94303	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 4 protocols, and no deviations of care were identified. A phone interview was conducted with Staff A, Licensed Practical Nurse (LPN), on at approximately 1:40 PM who revealed the staff worked on , the resident told her she had , and pointed to her belly, she reported it to the practitioner and , were ordered. The staff recalls the resident was at baseline, wheeling self around the building, she had an with good results and ate dinner. The staff stated she does not recall getting prior reports that the resident was ˬ but recalls reports of . The staff is not sure when the episodes of occurred two or three days prior to her shift on as she did not have her notes available and does not recall if vital signs were taken as the resident was at baseline. An interview was conducted with the DON on at approximately 1:50 PM who confirmed the fax ˬ complaints of ˬ and the physician response prescribing did not make it to the clinical record, there were no orders written, and she would complete an incident report. A follow-up interview with the DON on at 2:16 PM confirmed there are no documented vital signs after , there is no evidence the staff re-approached and attempted to obtain the prescribed work after the resident refusal, and confirmed the nursing staff did not document the resident had ˬ or . The investigation determined the nursing staff did not assess Resident #1 to monitor for continued changes in condition. There was no evidence that the staff monitored vital signs from	N 201		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	94303	A. BUILDING: _____ B. WING _____	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 201	Continued From page 5 through . There is no documentation of Resident #1 refusing vital signs. The record validates the resident started to exhibit signs of ⌄ complaints on . The nurse failed to document the resident was ⌄ and how often it occurred and failed to document and implement the physician's orders to treat the ⌄ with . The nurse failed to document episodes of and how often it occurred, as it was reported by Staff A during her interview. The nurse documented the work was completed on the Treatment Administration Record (TAR) dated . The investigation determined the resident refused it and there was no evidence that any further attempts were made to complete the laboratory studies or to initiate the fluids. Resident #1 had and was well known to the staff. There was no evidence the staff tried to reapproach the resident at a later time to complete the testing and treatment. Class III	N 201		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105277	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Complaint survey, complaint number 2025004445, was conducted on and concluded on at Stuart Rehabilitation And Healthcare. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, the facility failed to appropriately assess 1 of 2 sampled residents experiencing changes in condition, Resident #1, as evidenced by the lack of monitoring signs and symptoms of a obstruction, that included , , / , and . The findings included: Clinical record review conducted on revealed Resident #1 has been a long-term care resident at the facility since . Review of the Minimum Data Set (MDS) quarterly assessment, with reference date , documents Resident #1 was assessed as	F 684	Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.The Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law. What corrective action(s) will be accomplished for those residents found to have been	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed /2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105277	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 severely , for skills of daily decision making; is always of and ; has active diagnoses of ; and is dependent on staff for activities of daily living (ADLs). Revie of the Care plan titled, At risk for , related to decrease self-mobility, last revised , documents interventions as: "observe for and report to medical doctor complications related to , : change in mental status, new onset , sleepiness, inability to maintain posture, agitation, , , distension, , small loose stools, fecal smearing, decreased sounds, diaphoresis, tenderness, guarding, rigidity and fecal compaction." The electronic record revealed a nurse's note communicating to the physician via fax dated . The nurse advised the physician that Resident #1 was , and the nurse requested medication. The physician replied with an order for 4 milligrams every six hours as needed. Review of the Progress notes dated documents, "Resident remains in bed at this time and will not allow staff to get her up. Resident did not eat breakfast this morning and would not allow staff to feed her. Vital signs stable. Resident fought this nurse when the , cuff was applied but ultimately allowed vitals to be obtained. . Resident continues to sleep but is responsive and easily roused." Review of the Advance Practitioner Registered Nurse (APRN) notes dated documents,	F 684	affected by the deficient practice. The resident (Resident #1) was sent to the hospital for evaluation and treatment. The family declined surgical intervention and the resident was placed on Hospice services. A medication error was completed for the omission of the medication ordered on . The nurse completed an online Medication Error Prevention course on . How will you identify other residents having potential to be affected by the same deficient practice. An audit was completed on to ensure that no other residents had an unidentified change in condition. No other residents were identified. What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur. Licensed nursing staff were educated on for the need to complete a Change in Condition Observation in the Electronic Medical Record and to continue monitoring the resident for a minimum of 72 hours which	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105277	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2 "Seen in bed , vital signs stable. Patient not eating, won't get out of bed which is not her norm. Patient did one episode yesterday." Review of the APRN notes dated documents, the resident "was seen in the hallway, has resolved, and tests were negative. The resident refused fluids and laboratory studies." Review of the Progress notes dated documents as follows: "Resident noted to be choking while swallowing thin liquids. APRN notified and new orders for speech consult." "APRN notified of resident's abdomen is distended and causing her discomfort. New orders to give a and a KUB (, , and) stat." "APRN was notified of resident produced a large post ." "APRN was notified of KUB results." Review of the x-rays results dated documents, "mild to moderate ileus, follow up is needed." Review of the vital signs report and progress notes indicated the last documented vital signs for Resident #1 were dated . Review of the Progress notes dated documents the resident "noted with no sounds in any quadrant. Emergency services were called to send the resident out. APRN aware. Family notified." The record failed to document Resident#1's	F 684	will include vital signs, change in condition progress notes each shift, and notification & updates to the physician and family. Nurses have also been educated that they must notify the physician by phone when they initiate a Change in Condition Observation. The Nurses have been re-educated that all physician orders must be entered into the electronic medical record under Orders upon receipt of a new physicians order. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. The DON or designee will monitor the Change of Condition Observations initiated by a notification in the Messages tab of the Electronic Medical Record on a daily basis. The DON or designee will schedule a change of condition progress note for every shift for the next 72 hours after the initial Change of Condition Observation has been completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105277	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3 condition or vital signs prior to transfer. Review of the Hospital records indicate Resident #1 arrived at the emergency department via ambulance, with complaints of and distention for two days. Rescue states, as per nursing staff, the patient had ileus found two days ago. The patient has and is oriented to person. The record indicates the resident arrived with unstable vital signs, , , , level 90 percent on room air. Laboratory studies indicate increased count, decreased , levels, and abnormal , function. of the abdomen revealed the following: 1. , with severe fecal impaction that extends out through the to the upper abdomen. The measures 11 cm in diameter and the measures 12 cm in diameter and is distended with dense appearing , extends through the splenic flexure. There is wall thickening of the descending , and likely reflecting stercoral . 2. , . Large amount of , from , likely related to the severe fecal impaction/stercoral , Recommend General Surgery consultation. The emergency department notes documents, "Patient with , signs on exam. Lab studies consistent with , . Discussed with general surgery. Awaiting imaging. ...After imaging patient with , , in the setting of severe , and would require , ... Plan for hospice care with [Name provided] hospice. Patient to be admitted."	F 684	The DON or designee will audit all Change of Condition Observations twice a week for completion and follow up. Findings will be reported monthly to the QAPI committee for a period of 3 months and or until substantial compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105277	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 4	F 684		

An interview was conducted with the Director of Nursing (DON) on at 12:34 PM who revealed the facility reviewed the care provided to Resident #1 after she learned the resident had a obstruction and the staff reviewed the protocols, and no deviations of care were identified.

A phone interview was conducted with Staff A, Licensed Practical Nurse (LPN), on at approximately 1:40 PM who revealed the staff worked on , the resident told her she had , and pointed to her belly, she reported it to the practitioner and , were ordered. The staff recalls the resident was at baseline, wheeling self around the building, she had an with good results and ate dinner. The staff stated she does not recall getting prior reports that the resident was ˳ but recalls reports of . The staff is not sure when the episodes of occurred two or three days prior to her shift on as she did not have her notes available and does not recall if vital signs were taken as the resident was at baseline.

An interview was conducted with the DON on at approximately 1:50 PM who confirmed the fax ˳ complaints of ˳ and the physician response prescribing did not make it to the clinical record, there were no orders written, and she would complete an incident report.

A follow-up interview with the DON on at 2:16 PM confirmed there are no documented vital signs after , there is no evidence the staff re-approached and attempted to obtain the prescribed work after the resident refusal, and confirmed the nursing staff did not document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105277	A. BUILDING _____ B. WING _____	C 04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STUART REHABILITATION AND HEALTHCARE	1500 SE PALM BEACH RD STUART, FL 34994

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 5 the resident had ␣ or . The investigation determined the nursing staff did not assess Resident #1 to monitor for continued changes in condition. There was no evidence that the staff monitored vital signs from through . There is no documentation of Resident #1 refusing vital signs. The record validates the resident started to exhibit signs of ␣ complaints on . The nurse failed to document the resident was ␣ and how often it occurred and failed to document and implement the physician's orders to treat the ␣ with . The nurse failed to document episodes of and how often it occurred, as it was reported by Staff A during her interview. The nurse documented the work was completed on the Treatment Administration Record (TAR) dated . The investigation determined the resident refused it and there was no evidence that any further attempts were made to complete the laboratory studies or to initiate the fluids. Resident #1 had and was well known to the staff. There was no evidence the staff tried to reapproach the resident at a later time to complete the testing and treatment.	F 684		