

Agency for Health Care Administration

|                                                                           |                                                                                                                                              |                                                                                        |                                                                                                                          |                          |                                                        |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11932598</b>         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/11/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>RESIDENCE OF STUART, INC. (THE</b> |                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1048 N. FORK ROAD<br/>STUART, FL 34994</b> |                                                                                                                          |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                 | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                                     | Initial Comments<br><br>An unannounced Post Assessment Monitoring<br>visit was conducted on 10/11/2024 at Residence<br>Of Stuart, Inc (The). | A 000                                                                                  |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE