

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106012	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2025
NAME OF PROVIDER OR SUPPLIER Life Care Center of Port Saint Lucie		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 SE Jennings Rd Port Saint Lucie, FL 34952	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51137</p> <p>Based on interview, record review and policy review the facility failed to timely report to the State Agency allegations of abuse for 4 of 4 sampled residents (Resident #1 and Resident #4), and (Resident #5 and Resident #6) involved in an incident.</p> <p>The findings included:</p> <p>Review of the Policy titled Abuse-Reporting and Response - No Crime Suspected, issued on 10/04/22 and revised on 06/17/24 documented, in part . Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than later 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance to State law through established procedures.</p> <p>Review of the record revealed Resident #1 was initially admitted to the facility 01/13/25 and discharged [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had a Brief Interview for Mental Status (BIMS) score of 08, on a 0 to 15 scale, indicating the resident was moderately cognitively impaired.</p> <p>Review of the report documented an incident had occurred on 03/23/25 involving Resident #1. The incident was reported by the Administrator as followed: Incident Date 03/23/25, Incident time 7:01 AM, Administrator became aware of the incident 8:05 AM. Allegations: Physical Abuse. Time reported to the Abuse Registry 8:25 AM. This report was not submitted to the State Agency until 11:02 PM, approximately 16 hours after the incident occurred.</p> <p>During an interview on 04/01/25 at 11:20 AM, when asked why the abuse report for Resident#1 was not submitted timely, the Administrator stated that he was not aware he had to report it to the State Agency within 2 hours of the incident. He stated he thought he only had to report it to adult protective services within 2 hours. After a side-by-side review of the timeframes and regulation, he agreed that he should have completed the immediate report to the State Agency within 2 hours.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the record revealed Resident #4 was admitted to the facility 01/10/25 and discharged [DATE]. Review of the MDS assessment dated [DATE] documented Resident #4 did not have a BIMS score, indicating the resident was unable to answer any of the interview questions.</p> <p>Review of the report documented an incident occurred on 01/15/25 involving Resident #4. The incident was reported by the Administrator as followed: Incident Date 01/15/25. Incident time 10:04 AM. Administrator became aware of the incident 10:56 AM. Allegations: Physical Abuse. Time reported to the Abuse Registry 12:11 PM. This report was not submitted to the State Agency until 01/16/25 at 3:44 PM, more than a day after the incident occurred.</p> <p>Review of the record revealed Resident #5 had a re-entry admission to the facility on [DATE] and discharged [DATE]. Review of the MDS assessment dated [DATE] documented Resident #5 had BIMS score of 12, on a 0 to 15 scale, indicating the resident was cognitively intact.</p> <p>Review of the record revealed Resident #6 had a re-entry admission to the facility on [DATE]. Review of the MDS assessment dated [DATE] documented Resident #6 had BIMS score of 15, on a 0 to 15 scale, indicating the resident was cognitively intact.</p> <p>Review of the abuse incident that occurred on 12/11/24 documented an incident that had occurred between Resident #5 (the perpetrator) and Resident #6 (the victim.) The incident was reported by the Administrator as followed: Incident Date 12/11/24. Incident time 6:14 PM. Administrator became aware of the incident on 12/11/24 at 6:33 PM. Allegations: Physical Abuse. Time reported to the Abuse Registry 7:40 PM. This report was not submitted to the State Agency until 12/15/24 3:37 PM, approximately 4 days after the incident occurred.</p> <p>During a follow-up interview on 04/01/25 at 12:45 PM, when asked why the incident for Resident #4 and the Resident-to-Resident incident between Resident #5 and #6 was not reported timely, he repeated he was not aware of needing to report the incidents to the State Agency within 2 hours.</p>		