STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106012	A. Building B. Wing	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Port Saint Lucie	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)
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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review and interviews, the facility failed to provide services to avoid skin breakdown for 3 of 3 sampled residents, as evidenced by not performing skin assessments as ordered for Resident #4, #5, and #1. The findings included:Review of facility policy titled Area of Focus: Basic Skin Management revised on 11/21/2024, documented in part, The facility must ensure that a resident receives care consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical conditions demonstrate they were unavoidable and a resident with ulcer receives necessary treatment and services consistent with professional standards, to promote healing, prevent infection, and prevent new ulcer from developing. 2. All residents have a head-to-toe skin inspection upon admission/readmission, then completed weekly, and as needed by nursing. This policy further documented the assessments were documented in their electronic medical record under NRSG: Weekly Skin and the nurse was to review the User-Defined Assessment (UDA) for assignments.1) Record review revealed Resident #4 was admitted to the facility on [DATE]. Review of comprehensive assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 14 on a 0-15 scale, indicating the resident was cognitively intact. During a phone interview on 10/14/25 at 10:45 AM, the daughter of Resident #4 stated, I just don't know why they were refusing to give me updates on my father's status when I called. He has pressure ulcers on his bottom and heels, the hospital said it is a stage 3 (a wound that has full-thickness skin loss that presents as a shallow open ulcer) wound on his buttocks, and the heels have the beginning of a sore.Review of the care plan dated 09/17/25 revealed a focus that Resident #4 had a break in skin integrity and an intervention for staff to do weekly skin checks.Review of the weekly skin assessments for Resident #4, revealed no skin assessments were done on the week of 09/08/25, 09/22/25, and 09/28/25. During an interview on 10/14/25 at 2:34 PM, when asked if Resident #4 had a pressure ulcer on admission, the Wound Care Nurse (WCN) stated, Yes. When asked if the resident had a wound when he was discharged to the hospital on [DATE], she stated, The wound was resolved on 09/16/25. When asked when skin assessments were done on a resident, she stated, On admission by the admitting nurse, I do a secondary skin check, and then it's done every seven days by the floor nurses assigned to the resident. When asked how the nurse knows when the skin assessment was due to be done, she stated, The UDA populates in the system for the nurse. When asked if there was an order written for the skin assessment, she stated, No, not that I'm aware of. When asked when skin checks done on Resident #4, the WCN stated on 09/16/25 and 09/18/25.2) Record review revealed that Resident #5 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE], documented the BIMS score as not able to be assessed. Review of physician orders revealed staff were currently treating two wounds.Review of the care plan revealed a focus that Resident #5 was at risk for unavoidable recurrent pressure injury development or decline of skin integrity due to weakness, prognosis, fragile skin with a goal the resident's skin injury will be healed. An intervention was for staff to do weekly skin checks.Review of the skin assessments for Resident #5 revealed that skin assessments were not done on the week of 10/05/25, 09/14/25, 09/21/25, 09/28/25, 08/17/25, 08/10/25, and 08/03/25, and no skin assessments were completed in the month of July. 3) Record review revealed Resident #1 was admitted to the facility on [DATE]. Review of the annual assessment documented a BIMS score of 15 on a 0-15 scale, indicating no cognitive impairment.Review of the care plan dated 09/16/25 revealed a focus that Resident #1 had a potential for pressure ulcer development and skin breakdown related to impaired mobility, bladder incontinence, diagnosis of peripheral vascular disease (decreased blood flow) with a goal that the resident will have intact skin free of redness blister discoloration. An intervention documented on this care plan was that staff do weekly skin checks.Review of the physician orders revealed an order dated 08/01/2024 instructed staff to complete weekly skin checks every day (7:00 AM to 3:00PM) shift on Thursday for skin monitoring.Review of the skin assessments for Resident #1, revealed that skin assessments were not done on 07/24/25, 07/31/25, 08/14/25, 08/21/25, 08/28/25, 09/04/25, 09/11/25, 09/18/25, 10/02/25, and 10/09/25.Review of the August and September Treatment Administration Record for Resident #1 revealed staff had signed acknowledging that the skin checks were done. During an interview on 10/15 at 09:18 AM, when asked how do you know when a resident is scheduled for a skin check Staff A, Licensed Practical Nurse (LPN) stated. It will pop up on the UDA in the computer to let me know it is due. When asked where do you document the skin assessment, she stated, I

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, record review and interview, the facility failed to provide care and services to address the nutritional status for 1 of 3 sampled residents, as evidenced by not weighing according to policy and addressing Resident #4's weight loss, in a timely manner.The finding included:Review of the facility policy titled, Weight monitoring, long term care revised 09/15/25, documented in part Weighing a resident in a long term care facility is an important part of assessing a resident's health. Following a routine weighing schedule helps detect weight changes. Unless otherwise specified, record residents' weight at the time of admission, weekly for 4 weeks, and then monthly. Keep in mind that many residents' have comorbidities that can cause unplanned weight changes and some residents require more frequent weight assessments. Implementation: compare the resident's weight with previous measurements to assess trends in weight gain or loss. If you have a weight change, assess the resident using a facility approved malnutrition screening tool (if in use at your facility). Notify the practitioner if weight changes are beyond the expected range. Record review revealed Resident #4 was admitted to the facility on [DATE]. Review of comprehensive assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 14 on a 0-15 scale, indicating no cognitive impairment.During an interview on 10/14/25 at 10:45 AM, Resident #4's daughter stated, I just don't know why they (the facility) were refusing to give me updates on my father's status when I called. He lost 34 pounds in less than a month of being there. Now he is in the hospital fighting for his life due to failure to thrive.Review of the documented weights for Resident #4, did not reveal a weight taken on 09/05/25, his admission date or within 24 hours of admission. The initial weight was taken on 09/09/25 which was 176.8 pounds. There was no weekly weight documented on 09/16/25. On 09/23/25 the recorded weight was 157.2 pounds, which indicated he had lost 21 pounds in 2 weeks. The resident was reweighed on 09/30/25 and his weight was 142.4 pounds, indicating a weight loss of 34 pounds. Review of the care plan revealed a focus that Resident #4 had a nutritional problem related to status post hospitalization due to fall, anemia, depression with a goal the resident will maintain adequate nutritional status as evidenced by maintaining weight within (95)% of 177# no signs of malnutrition, and consuming at least (75)% of at least (2)meals daily with an intervention of the staff to observe for and report to MD as needed signs of malnutrition: Emaciation(Cachexia), muscle wasting, significant weight loss: 3lbs in 1 week,>5% in 1 month, >7.5% in 3 months, >10% in 6 months. Review of the progress notes did not reveal documentation of Resident #4 weight loss reported to the physician.Review of a progress note dated 09/25/25 revealed documentation of a care plan meeting held with Resident #4 and his daughter and stated that the current plan of care, medications, care preferences, treatments, therapy progress, diet and care plan was reviewed, and the resident remained stable with no changes.During an interview with the Unit Manager (UM) on 10/14/25 at 1:02 PM, when asked, did you notice a change in the resident's appetite, she stated, No change in his appetite, no real concern with him refusing food. When asked what the process is for obtaining weights, the UM stated, Usually there is an order. When asked what if there isn't an order, she stated then its monthly. When asked when the resident is usually weighed when they are admitted , she stated, Upon admission. When asked what she meant, she stated, When they arrive that day or the next day if not done at that time. When asked who is responsible for doing the weights, she stated, the CNA assigned, the day shift (7:00 AM TO 3:00 PM) does the even numbered rooms and the 3:00 PM to 11:00 PM shift does the odd numbered rooms. When asked who enters the weights in the record, she stated, The floor nurse assigned or me. The dietician will review the weights, and we have a weekly meeting to discuss weight changes. When asked what she would do if she noted a significant change in a resident's weight, she stated, I would call the doctor and get and order for a reweigh. I would reweigh the resident to make sure it's accurate. The UM was asked to review Resident #4's weights, after her review, she was asked when did the resident have a significant change in his weight, She stated on 09/23/25. When asked if there was a change in condition done for the significant weight loss the resident, she stated I don't see one in the computer, but I will talk to the Director of Nursing (DON). When asked was the weight loss discussed in the care plan meeting, she looked in the record and stated, On 09/25/25 there was an IDT meeting and it stated the diet, weights, medications were discussed, and no changes were made. When asked was the daughter present, she stated, Yes the resident and daughter was present. When asked what interventions were done for the weight loss and when were they initiated She stated on 10/1/25 the dietician ordered weekly weights, medpass and fortified foods