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No. 0938-0391

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	01/29/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure comfortable room temperatures for 7 of 7 sampled residents who voiced complaints, as evidenced by uncomfortably cold room temperature readings below 71 degrees F (Fahrenheit) in the rooms of Resident #129, #128, #131, #76, #81, #105, and #83.The findings included:Review of the weather history at https://www.localconditions.com/weather-port-saint-[NAME]-florida/34952/past.php, revealed the following low temperatures during the survey week: On Monday 01/26/26 at 11:00 PM the temperature had dropped to 61 degrees F. On Tuesday 01/27/26 hourly temperature ranged from a low of 46 degrees F. to a high of 60 degrees F. On Wednesday 01/28/26 the low temperature at 6 AM was 39 degrees F. The high temperature reached 67 degrees F. at 3:00 PM, with the temperature dropping to 49 degrees F. at 11:00 PM. On Thursday 01/29/26 the low temperature was 37 degrees F. at 4:00 AM with a high of 65 degrees F. at 2:00 PM. Further review of the 30-day weather history revealed the following: On 01/20/26 the low temperature was 45 degrees F. with a high of 66 degrees F. On 01/19/26 the low temperature was 40 degrees F. with a high of 63 degrees F. On 01/16/26 the low temperature was 41 degrees F. with a high of 62 degrees F. On 01/15/26 the low temperature was 51 degrees F. with a high of 63 degrees F. On 01/02/26 the low temperature was 46 degrees F. with a high of 68 degrees F. On 01/01/26 the low temperature was 38 degrees F. with a high of 69 degrees F. On 12/31/25 the low temperature was 44 degrees F. with a high of 67 degrees F. 1) Review of the record revealed Resident #129 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 he was cognitively (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intact. During an interview and observation on 01/27/26 at 9:50 AM, when asked how he was doing, Resident #129 stated, I'm freezing. An observation revealed the resident in bed covered up to his neck. When asked if he told anyone, he stated he told the CNA (Certified Nursing Assistant) who stated she would tell the nurse. When asked his preference regarding the room temperature, the resident stated he usually kept his house at 72- or 74-degrees F. On 01/27/26 at 9:59 AM, using the Agency issued thermo-hygrometer, the room temperature read 68.0 degrees F. The thermostat on the wall was set to 78 degrees with a room temperature reading of 67 degrees. Photographic evidence obtained. At that time the resident's family member came into the room, and when asked how he was doing in Spanish, Resident #129 stated in Spanish, Tengo frio (I'm cold). On 01/28/26 at 11:34 AM, when told he was observed earlier that day with the blanket over his head, Resident #129 stated, I'm freezing, further commenting that the last few days have been like being in New York. When told the thermostat in his room was between 67 and 70 degrees, he stated, 70 is still cold. The resident stated he was going to put on a sweatshirt when he got up for therapy. On 01/28/26 at 11:45 AM, using the Agency issued thermos-hygrometer, the room temperature read 70.3 degrees. The thermostat on the wall of the resident's room was set at 78 degrees with the room temperature reading was 68 degrees. Photographic evidence obtained. 2) Review of the record revealed Resident #128 was admitted to the facility on [DATE]. The MDS had not yet been completed but the nursing admission evaluation documented the resident as being alert and oriented. An observation in the room of Resident #128 on 01/28/26 at 10:14 AM revealed a temperature of 69.4 degrees as per the Agency issued thermo-hygrometer. The wall thermostat in the room was set to 85 degrees with a room temperature reading of 68 degrees. During an interview on 01/28/26 at 1:46 PM, when asked if she had been comfortable, Resident #128 stated it had been cold in the building. 3) Review of the record revealed Resident #131 was admitted to the facility on [DATE]. On 01/28/26 at 11:48 AM, when asked if she was warm, the resident stated, yes, with this on, referring to the heavy sweater she was wearing. On 01/28/26 at 11:53 AM the temperature in the room of Resident #131 was at 70.7 degrees using the Agency issued thermo-hygrometer. The room lacked any thermostat. Upon leaving the room, cold air was felt coming from the ceiling vent at the door. The temperature at the door was 67.4 degrees. Photographic evidence obtained. 4) Review of the record revealed Resident #76 was admitted to the facility on [DATE]. During an interview on 01/28/26 at 12:24 PM, the resident stated it was too cold in her room. The resident stated it had been cold the past couple of days and that she had to ask for extra blankets. The resident further stated it was cold in her room a week or so earlier with the last cold snap. An observation on 01/28/26 at 12:29 PM revealed the temperature reading, using an Agency issued (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thermo-hygrometer, was 69.6 degrees. 5) Review of the record revealed Resident #81 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented a BIMS score of 15. During a medication administration observation on 01/27/26 at 1:50 PM, the resident stated it had been cold in the room last night. On 01/28/26 at 12:34 PM, Resident #81 stated it was still freezing in his room. An observation of the Agency issued thermo-hygrometer read 70.3 degrees. Photographic evidence obtained. The resident explained since he had been at the facility, anytime it had been cold outside it was freezing in his room. On 01/27/26 at 10:18 AM, while in the hallway of the 200 unit, Staff B, Licensed Practical Nurse (LPN) stated, It's cold in here. When asked if she has had resident complaints, the LPN stated she had and had reported it to maintenance. On 01/28/26 at 10:18 AM, three maintenance men and a corporate consultant were observed in the common area of the 400 unit, with one of them on a ladder with the ceiling tile removed. When asked what the issue was with the lack of heat, the corporate consultant stated, Old AC from the 1990s and we can't get parts. We have to go up and adjust it manually. When asked what plan they had in place or what had been done as they should have been aware of the dropping temperatures, the corporate consultant stated, I'll have to find out. On 01/28/26 at 12:00 PM the temperature in the therapy room, as per the thermo-hygrometer read 69.4 degrees. During an interview on 01/28/26 at 2:32 PM, when asked how he kept the building warm and comfortable for the residents, the Maintenance Director explained some of the rooms had individual thermostats that could be adjusted, while the rest of the resident rooms and general areas were controlled by an old computer in the maintenance room. The Maintenance Director explained he had to go onto the computer and manually change the temperatures for each room or area. When asked about this week's cold snap and the cold temperatures in the building, the Maintenance Director explained he arrived at the facility about 7:30 AM on Tuesday, did his outside rounds, and about 8 AM had met with an outside company and was walking the building to get a quote for individual thermostats in the resident rooms. The Maintenance Director explained he adjusted the main computer thermostats when he heard some resident complaints that morning. When asked why the computer temperatures had not been adjusted Monday night with the pending cold temperatures, the Maintenance Director stated, I really didn't know it was going to get cold. 6) During an observation on 01/27/25 at 2:25 PM Resident #83 was noted in her recliner under a blanket shivering. She stated, It's really cold in here. The thermostat on the wall in her room read 68 degrees. The regional nurse then came down the hallway and overheard the resident complaining of it being cold. He went and got the resident more blankets. The regional nurse stated, The maintenance guys are working on the heat now. During an observation on 01/27/26 at 2:56PM, the temperature on hallway of the Bayside (4Unit) was 70.5 degrees, measured with the agency issued thermo-hydrometer. ([NAME]) (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/26 at 1:32 PM, when asked how did you rest last night, Resident #83 stated, It was still cold. 7) Record review revealed Resident #105 was admitted to the facility on [DATE]. Review of a comprehensive assessment dated [DATE], documented a Brief Interview Mental Status (BIMS) score of 15, on a 0-15 scale indicating no cognitive impairment. During an interview with on 01/28/26 at 9:45 AM, when asked how are you, Resident #105 stated It was very cold last night. The maintenance guys were here last night checking the temperature in my room, and it was 67 or 68 degrees. They said they would come back but I didn't see them. I had to sleep with 3 blankets last night. We had this problem a couple of weeks ago when it was cold. It took them 3 days to get the heat working. During an observation on 01/28/26 at 9:55 AM, the temperature in Resident #105's room that was checked with the agency issued thermo-hydrometer, the temperature was currently 68 degrees in her room. During an interview on 01/29/26 at 10:20 AM, Resident #105 was noted lying in bed underneath several blankets. When asked how the temperature in your room was last night, she stated, Still cold. 8) On 01/28/26 at 7:15 AM this surveyor began completing air temperatures in the hallways and two rooms of the facility with an Agency issued thermo-hygrometer . Resident #81 was observed to have two blankets over him. The room temperature in his room was 67.1 Fahrenheit. Resident #129's room temperature was 66.9 Fahrenheit. The hallway temperatures by room [ROOM NUMBER] was 66.5 Fahrenheit. and by room [ROOM NUMBER] was 66.7 Fahrenheit On 01/29/26 at 7:25 AM the air temperatures were taken again for Resident #81, the room temperature was 67.6 Fahrenheit and in Resident #129's room, the room temperature was 69.8 Fahrenheit. The hallway on the 400 unit by the nurse's station was 70.1 Fahrenheit. The main dining room was 69.4 Fahrenheit. During an interview on 01/28/26 and 01/29/26 at 7:30 AM with Resident #81, he stated it was so cold in his room. He only had two very thin blankets. He was so angry and couldn't wait to leave the facility.

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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 record review and interview, the facility failed to follow physician orders for 1 of 5 sampled residents as evidenced by failure to administer blood pressure medication as ordered for Resident #4. The findings included:Record review revealed Resident #4 was admitted to the facility on [DATE]. Review of the comprehensive assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 10 on a 0-15 scale, indicating moderate cognitive impairment. Review of the Medical diagnosis for Resident #4 revealed a history of Essential Hypertension (high blood pressure), Cognitive Communication Deficit.Review of the care plan dated 11/26/25 documented a focus that Resident #4 had Hypertension with a goal that the resident will remain free from complications related to Hypertension with interventions that staff will give Resident #4 antihypertensive medication as ordered. Review of a physician order dated 01/14/26, instructed staff to check Resident #4 blood pressure every 8 hours, give clonidine HCL by mouth every 8 hours as needed for systolic blood pressure (top number) over 160. A second order dated 1/14/26 instructed staff to give Clonidine HCL 0.1mg by mouth every 8 hours as needed for systolic blood pressure over 160. Review of the January 2026 Medication Administration Record (MAR) for Resident #4 revealed the following. documentation: B/P 161/90 (1/15/26 at 10:00 PM), B/P 168/88 (1/15/26 at 10:00 PM), B/P 169/84 (01/17/26 at 6:00 AM), B/P 186/93 (01/22/26 at 10:00 PM), B/P 161/75 (1/24/26 at 2:00 PM), B/P 175/84 (01/26/26 at 10:00 PM), B/P 178/98 (01/27/26 at 10:00 PM). Further review of the MAR revealed that staff administered the clonidine only on 1/22/26 at 9:48 PM and 1/26/26 at 11:07 PM.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure care and services for respiratory care for 4 of 5 sampled residents as evidenced by failure to ensure Resident #4 and #1 was provided oxygen, failure to ensure Resident #83 received breathing treatments as ordered, and failure to ensure Resident # 131's oxygen tubing was stored properly.The findings included:1) Record review revealed Resident #4 was admitted to the facility on [DATE]. Review of the comprehensive assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 10 on a 0-15 scale, indicating moderate cognitive impairment. Review of the medical diagnosis for Resident #4 revealed a history of acute and Chronic Respiratory Failure and Cognitive Communication Deficit. During an observation on 01/26/25 at 2:20 PM, Resident #4 was noted sitting in her wheelchair wearing oxygen via nasal cannula. The nasal cannula was only in one nostril. Review of a physician order dated 12/01/25 revealed instruction for Resident #4 to wear oxygen at 3 liters per minute per nasal cannula as need related to Acute and Chronic Respiratory Failure. Review of the vital signs for Resident #4 revealed the last documented oxygen saturation level was on 1/13/26. Review of the physician order dated 11/26/25, instructed staff to check Resident #4 vital signs, but the order did not include to check the oxygen saturation. Review of the care plan dated 12/15/25 documented a focus the Resident #4 has oxygen therapy related to Chronic Respiratory Failure with a goal that Resident #4's will have no signs or poor oxygen absorption with the intervention for staff to administer oxygen as ordered via nasal cannula, observe for signs and symptoms of respiratory distress and report to the doctor (respirations, pulse, oxygen saturation). During an observation on 01/27/2026 at 9:20 AM, the Assistant Director of Nursing was observed coming out of Resident #4s room. Surveyor entered the room after she walked out. The resident was noted lying in bed sleeping, the oxygen cannula was wrapped around the resident's face but not in her nostrils. During an observation on 01/28/26 at 1:26 PM, Resident #4 was observed sitting in her wheelchair, oxygen cannula on but only in one nostril. The resident's skin appeared pale. Resident #4 was asked Do you feel like you are getting air? She stated, I can't tell. Observation of the oxygen tank that was on the back of the resident's wheelchair, revealed that the tank was closed and displayed red but the tank was full. Photographic Evidence Obtained. An interview was conducted on 01/28/26 at 1:40, with Staff C, LPN in the conference room. She was asked if she had a pulse oximeter and she said yes. Staff C, LPN was asked to bring it with her to Resident #4s room. The resident was noted sitting in the wheelchair with the nasal cannula hanging out of 1 nostril. Staff C, LPN placed the pulse oximeter on the resident's finger, and her oxygen saturation read 79% initially and then went up to 82. She stated, let me check the oxygen tank. Staff C, LPN checked the tank and stated, Oh it's closed and it's a full tank. She opened the tank and the residents' oxygen slowly increased fluctuating between 83 to 84%. Staff C, LPN removed the oxygen nasal cannula from the oxygen tank and attached it to the oxygen flow meter on the wall above the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's bed. Resident #4's oxygen level increased to 92%. During an interview on 01/28/26 at 1:48 PM when asked how do you know when your resident needs oxygen if there is not an order to check the levels. Staff C, LPN stated, I checked Resident #4 oxygen level this morning. She was asked where did you document it, she had no response. During an interview on 01/28/26 at 1:52 PM, the DON was made aware that the resident's oxygen level was initially 79%, she had not received any oxygen from the tank on the back of her chair because it was closed. She asked who put her in the chair. The LPN stated, I'm not sure, I have to find out. During an interview on 01/28/26 at 2:08 PM, Staff D, Certified Nursing Assistant (CNA) was asked if she knew who transferred Resident #4 to the wheelchair this morning, she stated, I did and Staff E, Certified Nursing Assistant (CNA) helped me, we used the hoyer lift to transfer her. When asked did you attach the oxygen to the resident, she stated, Yes. During an interview on 01/28/26 at 2:15 pm, when asked if she assisted Staff D, CNA with transferring Resident #4 to the wheelchair, Staff E, CNA stated, Yes. 2) Record review revealed Resident #1's was readmitted to the facility on [DATE] after being hospitalized for pneumonia. Review of Resident #1 medical diagnosis revealed she had a history of Chronic Obstructive Pulmonary Disease (COPD) (restrict airway) and Chronic Respiratory Failure. Review of care plan date 1/06/26 documented a focus that Resident has COPD with an intervention that staff will Administer oxygen to the resident as ordered. During an observation on 01/27/2026 at 9:27 AM Resident, #1 was observed sitting in her wheelchair in her room with the oxygen nasal cannula on her face and attached to oxygen tank on her chair. The oxygen tank was noted to be empty. The resident stated it feels like it's empty, as she played with the nasal cannula in her nose. Review of a physician order dated 1/13/26 instructed staff that Resident #1 is to wear oxygen at 2 liter per minute continuously per nasal cannula. 3) Review of the record revealed Resident #83 was admitted to the facility on [DATE]. Review of the comprehensive assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 15, on a 0-15 scale, indicating no cognitive impairment. Review of the medical diagnosis for Resident #83 revealed a history of Chronic Obstructive Pulmonary Disease (COPD). During an interview on 01/27/2026 at 9:17 AM, when Resident #83 was asked do you receive the breathing treatments, she stated yes usually twice a day, early in the morning and at night. Review of a physician order dated 01/18/26 instructed staff to administer Resident #83, Ipratropium-Albuterol inhalation solution 0.5-2.5 3MG/3ML (breathing treatment) 1 Inhalation four times a day for COPD. During an interview on 01/27/26 at 2:17 PM, Resident #83 was noted to have a moist cough. She was asked if she had received the breathing treatment, she stated I got it early this morning. When asked (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if she had it that afternoon she stated, No its only twice a day, morning and night. During an interview on 01/28/26 at 1:10 PM, Resident #83's family member was at bedside visiting Resident #83, when the resident was asked had she received a breathing treatment today she stated, No, I've been out of my room all morning, because it was too cold in here. I went to get my hair done, then I was in the dining room. During review of the Medication Administration Record (MAR), documentation revealed that Staff F, Licensed Practical Nurse, (LPN) signed acknowledging she had administered Resident #83 the breathing treatment that was scheduled 01/28/26 at 12:00 PM. Further review of January MAR revealed that staff had signed acknowledging Resident #83 had received the breathing treatment four times a day as ordered. During an interview on 01/28/26 at 2:10 PM, when asked does Resident #83 have an order for breathing treatments, Staff F, LPN stated, Yes, I think they are prn (as needed). She went to review the prn orders in the resident's record and stated, yes, she has a prn order. Staff F, LPN, was asked to go to the resident's scheduled orders. She reviewed the MAR for that day and realized a breathing treatment was scheduled at 12pm, but she had already signed the record. Staff F, LPN was asked if the resident had received the breathing treatment that was scheduled at 12:00 PM, she stated, No, I will give her one now. Review of the Medication Audit revealed that Staff F, LPN, signed the MAR on 01/28/26 at 11:34 AM acknowledging that she had administered the breathing treatment due at 12:00 PM. 4) Review of the record revealed Resident #131 was admitted to the facility on [DATE]. Review of current physician orders documented the resident had orders for oxygen at 2 liters per minute via nasal cannula, as needed for shortness of breath, since admission. Review of the oxygen saturations level documented the resident had used the oxygen on both 01/22/26 and 01/23/26. A progress note dated 01/24/26 also documented the oxygen use for Resident #131. An observation on 01/26/26 at 2:16 PM revealed Resident #131 in bed sleeping. Oxygen tubing dated 01/22/26 was observed with the nasal canula lying directly on the floor. The tubing was connected to the oxygen which was running at 2 liters per minute. Photographic evidence obtained. An observation on 01/27/26 at 10:17 AM revealed the same oxygen tubing dated 01/22/26 that had been on the floor the previous day, was now hanging on the wall over the oxygen regulator. Photographic evidence obtained. When asked if she uses the oxygen, Resident #131 stated she wears it as needed, especially in the evening or at night. An observation on 01/29/26 at 10:45 AM revealed the same oxygen tubing, dated 01/22/26 that had been on the floor, was hooked to the oxygen regulator. During an interview on 01/29/26 at 10:43 AM, when asked what she would do if the oxygen nasal cannula was found on the floor, Staff B, Licensed Practical Nurse (LPN) stated she would throw it away. The LPN was told the tubing was noted on the floor a couple of days ago (01/26/26) and the same tubing was still in use. The LPN stated she would change it.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews the facility failed to ensure a proper assessment, obtain physician orders, a consent and assessment was done quarterly for 5 of 6 sampled residents reviewed for bed rails. (Resident #8, Resident #9, Resident #10, Resident #68 and Resident #71). The findings included:A review of the facility policy for Bed Rails issued 11/22/17, revised 12/30/22 and reviewed 09/03/25 documented: The facility must attempt to use appropriate alternatives prior to installing a side rail or bed rail. Review the risks and benefits of bed rails with the resident or representative and obtain consent prior to installation. Procedure: Residents will be assessed upon admission, readmission, or upon initiation utilizing the Evaluation for use of Bed Rails Assessment. If bed rails are determined to be appropriate a reassessment of bed rails use will be assessed at a minimum quarterly and potentially with a change of condition. The facility will document alternatives to the use of the bed rails and how the alternatives did not meet the resident's assessed needs prior to the utilization of the bed rails.1). Observations were made on 01/27/26 at 2:30 PM, 01/28/26 at 8:15 AM, and 01/29/26 at 9:30 AM of Resident #8, with the bed rails in the up position. Review of Resident #8's medical records revealed she was admitted to the facility on [DATE] with a readmission on [DATE]. Her diagnosis includes Seizures, Parkinson's Disease, Diabetes, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side. A review of her Bed Rail assessment dated [DATE] readmission documents question 1. Is the resident being considered for bed rails or assistive device for the bed? No. However, this resident was observed with the bed rails on her bed and in the up position. 2). Observations were made on 01/27/26 at 2:45 PM, 01/28/26 at 9:00 AM, and 01/29/26 at 7:30 AM of Resident #9, with the bed rails in the up position. Review of Resident #9 medical records revealed Resident #9 was admitted to the facility on [DATE] with a readmission on [DATE] from the hospital with a diagnosis to include Hospice, Muscle Weakness, Right and Left Knee Pain and Back Pain. A review of the bed rail assessment dated [DATE] documents question 1. Is the resident being considered for bed rails or assistive device for the bed? Yes. Question #2a, were appropriate alternatives attempted prior to considering bed rails? Yes, Question #23 Bed rail is recommended at this time due to conditions identified on evaluation. This question is not answered. There is not a physician's order, but does have a consent signed. The bed rail assessment is not being completed quarterly. Does not document what alternatives were tried and documented. However, this resident was observed with bed rails on the bed and in the up position. 3). Observations were made on 01/27/26 at 2:20 PM, 01/28/26 at 7:10 AM and 01/29/26 at 11:00 AM of Resident #10, with the bed rails in the up position. Review of Resident #10 medical records revealed he was admitted to the facility on [DATE] with a diagnosis to include Rachial Plexus Disorder, Rhabdomyolysis, End Stage Renal Disease, Muscle Weakness and Type II Diabetes. A review of the Bed Rail assessment dated [DATE], a readmission from the hospital documented 1. Is the resident being considered for bed rails or assistive device for the bed. YES. 2a. documented were appropriate alternatives attempted prior to considering bed rails. No. 2b. If no, then bed rails should not be placed on bed. Alternatives must be attempted prior to proceeding with placement of bed rails. If alternatives have been attempted and proven to be unsuccessful then a new evaluation needs to be completed. Further record review revealed there was no consent signed and no physician order. However, this resident was observed with bed rails on the bed and in the up position. 4). Observations were made on 01/27/26 at 2:25 PM, 01/28/26 at 8:25 AM, 01/29/26 at 7:45 AM of Resident #68, with the bed rails in the up position.Review of Resident #68's medical records revealed Resident #68 had been initially admitted to the facility on [DATE] with a readmission on [DATE], His diagnosis included Fracture Right Femur and Lower Back Pain. A review of the resident's bed rail assessment documented the (continued on next page)

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	106012	A. Building B. Wing	01/29/2026

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

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following. 1. Is the resident being considered for bed rails or assistive device for the bed. YES. 2a. documents were appropriate alternatives attempted prior to considering bed rails. No. 2b. If no, then bed rails should not be placed on be. Under Assessment it documents that he has had bed rails since 2022 but the last assessment was in 2025. However, this resident was observed with bed rails on the bed and in the up position. During an interview on 01/29/26 at 6:06 PM Staff N, MDS (Minimum Data Set) Coordinator, she stated that Resident #68 has had the bed rails on since 2022. Though under assessment it shows he did not have any assessment after 2025 until he went to the hospital and came back in 01/2026. 5). Observations were made on 01/27/26 at 2:50 PM, 01/28/26 at 7:40 AM and 01/29/26 at 9:00 AM of Resident #71, with the bed rails in the up position.Review of Resident #71 medical records revealed that she was admitted to the facility on [DATE] with a diagnosis to include History of Falling, Difficulty Walking, Pain to Right Knee, Pain to Back and Muscle Weakness. A review of the resident's bed rail assessment documented her last evaluation was done 11/27/24. and documented the following: 1. Is the resident being considered for bed rails or assistive device for the bed. YES. Further review revealed this resident has an assessment for bed rails completed but no physician order; the last assessment completed in 2024 and not being done quarterly and no consent signed.During an interview on 01/29/26 at 10:15 AM with Staff M Unit Manager she was asked when are the bed rail assessments done. She stated we complete all of them all on admission then they do them quarterly and physical therapy does it as well. She stated that the bed rails are up on admission and we automatically put them up .We don't get consents at that time nor do we get a physician's order.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview, and record review, the facility failed to ensure nursing staff clarified intravenous medication volume for 1 of 1 sampled resident, Resident #81, with IV medications. The facility failed to follow their medication administration policy by not preparing medications for one resident at a time and by failing to explain medications to residents during administration. This practice created a potential risk for medication error, including the possibility of medication exchange during the administration process. This deficiency involved 2 of 28 sampled residents. Residents #27 and #100. The findings included:1) Review of the facility policy titled, General Dose Preparation and Medication Administration, revised 11/15/24, documented staff were to compare the medication to the Medication Administration Record (MAR) to the prescription label prior to administration. Review of the policy, Admixing IV (intravenous) Medication, revised 05/01/24, documented staff were to verify prescriber order, inspect medication for integrity, expiration date, and strength, and to notify pharmacy if any questions. During a medication administration observation on 01/27/26 at 1:50 PM, Staff B, Licensed Practical Nurse (LPN) obtained the IV antibiotic cefepime, a 2-gram dose in 50 ml (milliliters) of dextrose to administer to Resident #81. The LPN hooked up the medication to the IV pump and administered it to Resident #81. Review of the physician order documented the cefepime 2 grams was ordered to be administered in 100 ml of dextrose. During a side-by-side review of the actual medication administered compared to the physician order, the LPN stated, but it says here 100 milliliters while pointing to the documented rate of administration which was 100 ml per hour. When told that was the rate of administration and not the concentration, the LPN agreed. When asked if what she administered was the correct concentration, the LPN agreed it was not. During an interview on 01/27/26 at 2:26 PM, when told the IV cefepime for Resident #81 that was administered was a different concentration than what was ordered, the Director of Nursing agreed with the findings and stated the nurse should have clarified the order. Review of the pharmacy Proof of Delivery for Resident #81 revealed the more concentrated cefepime in 50 ml of dextrose was delivered to the facility on [DATE]. Review of the January 2026 MAR revealed twelve different nurses administered the cefepime 2 grams in 50 ml of dextrose without clarifying the order. 2). The facility policy titled General Dose Preparation and Medication Administration, last revised on 11/15/24, required staff to: Prepare medications for only one resident at a time. Use a three-way check by comparing the medication to the medication administration record (MAR) and the prescription label. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility staff should not leave medications or chemicals unattended. Verify resident identification per facility policy (example picture, armband, name). Observe each resident's privacy and rights in accordance with applicable law (example knocking before entering the room, pulling privacy curtains, informing resident what is to occur before administration, blocking unnecessary access to the MAR.) Provide the resident with any necessary instructions, including explaining the medication use and possible side effects. Observe the resident's consumption of the medications. 2a). Clinical record review revealed Resident #27 was admitted on [DATE] with diagnoses including depression and psychotic disorder. The admission minimum data set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Review of scheduled morning medications included: Apixaban 5 mg, one tablet by mouth twice daily for deep vein thrombosis (scheduled 10:00 AM) Diltiazem 120 mg, one capsule by mouth daily for hypertension and chest pain (scheduled 10:00 AM) Acidophilus, one capsule by mouth twice daily (scheduled 8:00 AM) Multivitamin, one tablet by mouth daily for nutritional risk (scheduled 9:00 AM) 2b). Clinical record review revealed Resident #100 was admitted on [DATE] with diagnoses including cancer, bipolar disorder, and psychotic disorder. The significant change MDS dated [DATE] documented a BIMS score of 12, indicating Resident #100 was cognitively intact. Review of scheduled morning medications included: Apixaban 5 mg, one tablet by mouth every 12 hours for atrial fibrillation (scheduled 9:00 AM) Bupropion 150 mg, one tablet by mouth daily for depression/anxiety (scheduled 8:00 AM) Olanzapine 5 mg, one tablet by mouth twice daily for bipolar disorder (scheduled 8:00 AM) Colace 100 mg, one capsule by mouth daily for constipation (scheduled 9:00 AM) Cyanocobalamin 500 mcg, one tablet by mouth daily for neuropathy (scheduled 9:00 AM) Famotidine 20 mg, one tablet by mouth daily for indigestion (scheduled 9:00 AM) Folic Acid 1 mg, one tablet by mouth daily as a supplement (scheduled 9:00 AM) Lisinopril 20 mg, one tablet by mouth daily (scheduled 9:00 AM) (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Sunitinib 50 mg, one capsule by mouth daily for cancer treatment (scheduled 9:00 AM) On 01/26/26 at 11:07 AM, while the surveyor was present in the room interviewing Resident #27, Staff A, a licensed practical nurse (LPN), entered the room with medications for both residents occupying the room (Resident #27 in Bed A and Resident #100 in Bed B). Staff A handed a medication cup to Resident #27 while the privacy curtain remained open and immediately proceeded to Resident #100 and handed her a medication cup. Staff A did not explain the medications to either resident and did not provide privacy during the medication administration process. On 01/29/26 at 8:48 AM, during an interview with the Director of Nursing (DON), the surveyor described the medication administration observed involving Resident #27 and #100.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on facility policy, observation, record review and interview, the facility failed to ensure safe medication administration for 5 of 8 sampled residents as evidenced by failure to ensure narcotic reconciliation for Resident # 11, # 45, # 96, # 99 and #101. The findings included: Review of the facility policy General Dose Preparation and Medication Administration revised 11/15/25, documented in part 5. During medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 5.5 Document the administration of controlled substances in accordance with applicable law. Medication storage was conducted on 8 residents. Narcotic reconciliation was conducted for 01/28/26 at 1:00 PM with Staff F, Licensed Practical Nurse (LPN), during review of the Controlled Medication Utilization Record for Tramadol 50mg prescribe for Resident #11 documentation revealed on line 4 the time of administration of the Tramadol was not documented. Narcotic reconciliation was conducted on 01/29/2026 at 1:30 PM with Staff B, LPN, review of the Controlled Medication Utilization Record for Oxycodone 10mg IR prescribed for Resident #45 revealed documentation of a count of 7 remaining oxycodone, the pill packet revealed a count of 6 pills.During an interview on 01/29/25 at 1:32 PM, with Staff B, LPN, when asked if she knew why the count was wrong for Resident #45 oxycodone, she stated I gave him a pill this morning and I didn't sign it out. Can I do it now? Narcotic reconciliation was conducted on 01/29/2026 at 1:35 PM with Staff B, LPN, review of the Controlled Medication Utilization Record for Oxycodone 5mg IR prescribed for Resident #96 revealed no documentation on line 3 of the date and time the oxycodone was administered. Photographic evidence obtained Narcotic reconciliation was conducted on 01/29/26 at 3:00 PM with Staff C, LPN, review of the Controlled Medication Utilization Record for Oxycodone 10mg IR prescribed for Resident #99 revealed no documentation on line #2 of the time the oxycodone was administered on 01/25/26. Photographic evidence obtained Narcotic reconciliation was conducted on 01/29/26 at 3:10 PM with Staff C, LPN, review of the Controlled Medication Utilization Record for Oxycodone 5mg IR prescribed to Resident #101 revealed documentation of the medication being received on 01/10/26. Further review revealed documentation of the oxycodone administered on 01/13/26 at 4:00 PM and 01/13/26 at 11:19 PM. Review January Medication Administration Record (MAR) revealed no documentation of this medication being administered on 01/13/26. According to the MAR the medication was last administered on 01/01/26 and then discontinued on 01/09/26. Photographic evidence obtainedReview of the physician orders for Resident #101 revealed documentation of Oxycodone 5mg IR discontinued on 01/09/26. There was not an active order for Oxycodone 5mg IR on 1/13/26. During an interview with the Regional Nurse on 01/29/26 at 3:45P, he was made aware that staff administered Oxycodone 5mg IR to Resident #101 without an active order.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure proper monitoring of psychotropic medications as evidence by the AIMS (Abnormal Involuntary Movement Scale) for 1 of 5 sampled residents reviewed for unnecessary medications, Resident #9. The findings included:A review of the facility policy, titled, Tardive Dyskinesia (AIMS) initiated 06/08/20, revised 05/09/22 and reviewed on 08/29/25 documented that residents receiving antipsychotic medications require ongoing assessment for Tardive Dyskinesia. The procedure documents upon initiation of a medication with known extrapyramidal symptoms (EPS) side effects, the facility will complete a baseline Tardive dyskinesia AIMS Assessment and then every 3 months as needed thereafter for as long as the medication is being used.A review of Resident #9's medical records revealed that she was admitted to the facility on [DATE] with a diagnosis to include Unspecified Dementia, Psychotic Disturbance, Major Depressive Disorder, and Anxiety. Her physician orders included Seroquel Oral tablet 25 MG by mouth two times a day for psychosis. A review of the AIMS (Abnormal Involuntary Movement Scale) documented she had this completed on 08/01/25 with a score of 0.0.During an interview on 01/29/26 at 5:05 PM with the Assistant Director of Nursing she acknowledged that the AIMS should be done quarterly and would have been due in November of 2025.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the medication error rate was 9.38% percent. Three medication errors were identified while observing a total of 32 opportunities, affecting 3 of 5 residents observed (Residents #81, #7, and #117).The findings included: 1) A medication administration observation was made for Resident #81 on 01/27/26 at 1:50 PM. Staff B, Licensed Practical Nurse (LPN), obtained the medication cefepime 2 gm (grams) in 50 ml (milliliters) of dextrose to be administered via IV (intravenous) infusion. The LPN entered the room, hooked up the IV, and started the infusion. Photographic evidence obtained. Review of the record revealed the physician ordered IV medication was cefepime 2 gm in 100 ml of dextrose. When shown the photo of the IV medication and asked about the concentration of 2 gm/50 ml, the LPN stated, but it says here 100 ml/hr. When told that was the rate of administration and not the concentration, the LPN agreed. When asked if what she administered was the correct concentration, the LPN agreed it was not. During a side-by-side review of the record on 01/27/26 at 2:26 PM, the Director of Nursing (DON) agreed with the findings. 2) During an observation of medication administration on 01/28/25 at 8: 40 PM, Staff B, Licensed Practical Nurse (LPN) was observed pouring the following medications for Resident # 7: Oxcarbazepine 300mg 1 tablet, Clopidogrel 75mg 1 tablet, Quetiapine 25mg 1 tablet, Docusate Sodium 100mg 1 capsule, Apixaban 5mg 1 tablet, Lexapro 10mg 1 tablet, Aspirin 81mg 1 tablet, Glipizide 2.5 mg 1 tablet, Metoprolol Succinate 25mg ER 1 tablet, Acetaminophen 325 mg 2 tablets, Potassium Chloride 20meq 1 tablet, Senna-Plus 1 tablet. Review of physician orders and reconciliation of the medications administered for Resident #7 revealed the following physician order: Locosapent Ethyl (for cholesterol) 1 gm 2 capsules twice a day (8:00 am and 5PM). This medication was not administered during observation of med pass with Staff B, LPN. Review of January Medication Administration Record revealed that Staff B, LPN documented that she administered the medication to Resident #7 today. Further review of the MAR revealed documentation that staff had signed some days that the medication was administered and other days that it was not available. During an interview on 01/28/26 at 2:28 PM, Staff B, LPN was asked if she administered Locosapent Ethly to Resident #7 during med pass observation and she stated, I administered that medication before you observed me. She was asked to show the medication, she stated I gave the resident the last 2 this morning. She was asked to display on the record the last time the medication was reordered, in which it revealed that the medication was on order. She stated, I reordered the medication this morning. Review of the Medication Admin Audit Record revealed documentation that Staff B, LPN signed that she administered the Locosapent Ethyl scheduled for 8:00 AM at 8:41AM. During an interview on 01/28/26 at 5:42 PM, when asked when the last time Locosapent ethyl 1gm (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Resident #7 was reordered, Pharmacist stated, The last time this medication was reordered was in November 2025, 120 capsules, which was a 30-day supply During an interview with the DON she was made aware Staff B, LPN had acknowledged to surveyor that she administered Locosapent Ethyl to Resident #7 prior to med pass observation, but the medication was not available to be given. 3) During an observation of medication administration on 01/28/26 at 9:00 AM, Staff C, Licensed Practical Nurse, LPN was observed pouring the following medications for Resident #117: Aspirin 81 mg 1 tablet, Metolazone 2.5mg 1 tablet, Potassium Chloride ER 20 meq 1 tablet. Review of the physician orders and reconciliation of medications administered to Resident #117 revealed the following physician order: Symbicort Inhalation 160/4.5 MCG/ACT inhale 2 puffs orally twice a day for shortness of breath. Staff C, LPN did not administer this medication during med pass. Review of January MAR revealed documentation that Staff C, LPN signed the record acknowledging that the medication was administered during med pass. During an interview with Staff C, LPN, when asked if Resident #117 received any respiratory medications, she went into her med cart and pulled out a box of nebulizer medication. She was then asked does the resident received anything else, Staff C, LPN looked throughout the cart and found a Symbicort inhaler with the resident's name on it. She was asked if she administered the Symbicort to the resident during her med pass, she stated I gave it to her earlier before she took her other medications. Review of the medication admin audit report for Resident #117 on 01/28/26, revealed documentation that Staff C, LPN signed that she administered the Symbicort at 9:08 AM , when the other medications were administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, interview, and record review, the facility failed to ensure medications were not left unattended at the bedside for 2 of 35 residents reviewed (Residents #36 and #67). Additionally, the facility failed to ensure medication carts and medication rooms were free from expired medications for 1 of 9 medication carts and 1 of 3 medication rooms. The findings Included: The facility policy titled General Dose Preparation and Medication Administration, last revised 11/15/24, indicated that facility staff should not leave medications or chemicals unattended. 1). Clinical record review revealed Resident #36 was admitted on [DATE] with diagnoses including brief psychotic disorder, low vision of the right eye (category 1), blindness of the left eye (category 3), bilateral hearing loss, and dementia. The quarterly Minimum Data Set (MDS) assessment with a reference date of 10/29/25 documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS documented no mood or behavioral concerns. Further review of the clinical record revealed Resident #36 had the following scheduled morning medication orders: Quetiapine 100 mg, one tablet by mouth twice daily for brief psychotic disorder (scheduled at 9:00 AM and 9:00 PM). Namenda 10 mg, one tablet by mouth twice daily for dementia (scheduled at 9:00 AM and 9:00 PM) Review of the care plan, revised 11/03/25, documented that Resident #36 required antipsychotic medication related to brief psychotic disorder, with the intervention to administer antipsychotic medications as ordered by the physician. The care plan also documented impaired visual function related to total vision loss in the left eye and impaired vision in the right eye. Review of the Medication Administration Records (MARs) for January 2026 indicated the scheduled morning doses of Quetiapine 100 mg and Namenda 10 mg were signed as administered by the attending nurse. On 01/29/26 at 10:39 AM, record review revealed no documented self-medication assessment indicating Resident #36 was assessed and determined to be capable of self-administering medications. On 01/26/26 at approximately 11:00 AM, during an interview with Resident #36, the surveyor observed a medicine cup containing two pills (one yellow and one grayish in color) left unattended on the bedside table. No nursing staff were present at the bedside at that time. Resident #36 was observed to be hard of hearing. On 01/29/26 at 8:48 AM, the Director of Nursing (DON) was informed that medications had been observed left unattended at the bedside for Resident #36. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/26 at 11:06 AM, the surveyor reviewed the medication packets for Resident #36's scheduled morning doses of Namenda and Quetiapine and compared them with the medications observed at the bedside. The medications were consistent in appearance with those found in the unattended medication cup. On 01/29/26 at approximately 12:28 PM, during a subsequent interview, the DON stated she reviewed Resident #36's medication records and confirmed that the medications left unattended at the bedside were Quetiapine and Namenda and stated those medications should have been administered by staff. 2) Record review revealed Resident #67 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 15 on a 0-15 scale, indicating no cognitive impairment. During an observation on 01/26/2026 at 11:32 AM, 2 white bottles of medication with a gray top were noted on Resident #67's nightstand. The larger bottle was labeled Omega Guard. Photographic evidence obtained. Review of the assessments for Resident #67, did not reveal a self-medication administration assessment completed for the resident to self-administer medications. During an observation on 01/27/2026 at 9:20 AM, 2 white bottles of medication with a gray top were noted on Resident #67s nightstand. The larger bottle was labeled Omega Guard and the small bottle with a black label was labeled Lecithin. Photographic evidence obtained. Review of the physician orders for Resident #67 did not reveal an order for Omega Guard or Lecithin. During an interview with Resident #67, she was asked what happened to the 2 bottles of medication that were sitting on her nightstand. She stated They took them and told me they had to be locked up. I will continue taking them when I go home Medication storage was conducted on 01/28/26 at 12:25 PM with the Unit Manager on Bayvista (4U), observation of the med room revealed 2 opened, unlabeled insulin vials were inside a zip lock bag and stored in the refrigerator. Photographic evidence obtained. Medication storage was conducted on 01/29/26 at with Staff B, Licensed Practical Nurse (LPN) on Bayvista, observation of the med cart revealed several bottles of expired medications in the cart. Photographic evidence obtained.