

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968931	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/12/2022
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VITALITY RESORT ALF LLC

**1258 ERMINE ST
PORT SAINT LUCIE, FL 34953**

(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
A 000	Initial Comments An unannounced Relicensure with Limited Mental Health (LMH), Complaint (#2021015155), and a Generator Monitoring survey were conducted on at Vitality Resort ALF LLC. The facility had a deficiency identified related to the Relicensure at the time of the survey.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing	A 054		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968931	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/12/2022
NAME OF PROVIDER OR SUPPLIER VITALITY RESORT ALF LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1258 ERMINE ST PORT SAINT LUCIE, FL 34953		
(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	
A 054	Continued From page 1 physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined the facility failed to ensure the Medication Observation Record (MOR) was up-to-date for 3 out of 5 sampled residents (Residents #1, Resident #4 and Resident #5) who required assistance with the self-administration of medication. The findings included: During review of the _____ MOR's on _____, the following omissions and errors were identified: 1) Resident #1 a. 8:00 PM doses from _____ through _____ were not initialed as given for _____. 2) Resident #4 a. 8:00 AM dose on _____ had not been initialed as given for _____. 3) Resident #5 a. 8:00 AM dose on _____ had not been initialed as given for _____. The Administrator was notified of these findings during an interview conducted on _____ at 10:40 AM. The facility provided no additional information for review at this time. Class III	A 054			