Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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<br><br>An unannounced Complaint (#2025010370 & #2025014906) and Generator Monitoring survey were conducted on , at Wickshire Port St. Lucie. The facility had deficiencies related to complaints #2025010370 and #2025014906 identified at the time of the visit. | A 000 | | |
| A 030 | 59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures<br><br>59A-36.007<br>(5) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C.<br>(b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint.<br>(c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The | A 030 | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 1 | A 030 | | |

telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and
, ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 2<br><br>must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside.<br><br>429.28 Resident bill of rights.-<br>(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:<br>(a) Live in a safe and decent living environment, free from and neglect.<br>(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.<br>(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.<br>(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.<br>(e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.<br>(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or | A 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 3 | A 030 | | |

attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 4<br><br>resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.<br>(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.<br>(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a | A 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 5<br><br>resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.<br><br>429.27 Property and personal affairs of residents.-<br>(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.<br>(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review and interviews, the facility failed to demonstrate their Grievance Policy and Procedure for receiving and responding to resident complaints was effective for 3 out of 3 sampled residents (Residents #1, #2 and #3).<br><br>The findings included: | A 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 6<br><br>The facility's Grievance Policy and Procedure notes that the facility "will encourage all residents and family members to express their grievances" and "will be responsive to reasonable concerns and suggestions". It also states that "the resident will be asked if they wish to put an oral grievance in writing" and that only the written grievances will be logged. It also documents that "within seven (7) business days after receiving a grievance, the community will give the complainant a written decision explaining the investigation findings and the action the community plans to take to resolve the grievance".<br><br>During interview with the Administrator on at 11:00 AM, the Grievance Log and Customer Service Grievance & Resolution Forms recorded for residents or their representatives was requested. There were three forms filed in 2025 available for review at this time.<br><br>1. During a telephonic interview with Resident #1's representative on at 10:23 AM, she confirmed that she had submitted a grievance by sending an email to the Administrator related to Resident #1's ant infestation in his room. She stated she has not received any response from the Administrator. Review of the email correspondence substantiates that the resident's representative emailed the following statements to the Administrator on :<br><br>a. First noticed ants the first week of , and reported it to several people. The Maintenance Director sprayed and did some very shoddy caulking in the bathroom, it did not eradicate the ants.<br>b. In mid- , ants were found in Resident #1's bed. Again, the Maintenance Director sprayed | A 030 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 7 | A 030 | | |

and put out bait. Then, about a week later, Resident #1 was seriously and bitten by ants in his bed.
c. The resident's room was changed when he returned from the hospital on .
d. A request for professional pest control was made at this time.
e. On , there were ants observed in the dining room along the baseboard.

Review of the resident's observation notes confirm that the resident was observed with "what appeared to be reddened to arm, , abdomen, lower extremity" and that hospice was notified for treatment on at 6:46 AM as noted by the DHW. It was also documented that the resident was sent to the hospital on for evaluation.

On , the pest control documentation was reviewed. There were monthly treatments for maintenance documented on , , , and . The next treatment was documented on . It is unknown why the company did not treat the facility in by the 8th to ensure consistency with the monthly maintenance plan. Additionally, during interview with the Administrator on at 2:00 PM, she acknowledged that the treatment was a maintenance visit, so no added ant prevention was initiated at the time. She indicated that the additional ant treatment that was in relation to the grievance was completed on and also by another company on . The documented response on the grievance form is that the maintenance company pest control representative was spoken to on and , and stated that there was additional treatment to the building perimeter on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 8<br><br>and that they would be at the facility at the end of the month to provide another treatment. Another company also treated the facility outside perimeter on .<br><br>There was no documented monitoring by the facility staff to ensure the ants were not able to enter the building into resident areas following Resident #1's incident on . Review of the Maintenance Director's log of pest control and identified areas that required treatment revealed there were ants in the "bed area" in on , ants in on , and "ants very bad" in on . During interview with the new Maintenance Director on at 10:50 AM, he acknowledged that only the rooms reported to the pest control company when they arrive for the monthly maintenance visit were treated for ants. It is not known why the facility did not identify the ant infested rooms for monthly treatment and inspection by the pest control company until the issue was alleviated.<br><br>Random resident rooms were observed in the secured unit on at 10:35 AM. had many ants observed in all corners of the room with a clear wet substance noticeable on the floor. During interview with the Administrator on at 1:30 PM, she stated the rooms are cleaned weekly. Therefore, the ants were still entering the building within the last week.<br><br>During observation of Resident #3 on at 10:30 AM, her right was observed with many small darker circular spots. During interview with Staff A at this time, she stated that the resident was bitten by ants on her . The resident was not able to communicate effectively due to , . Review of the | A 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 9<br><br>resident's observation notes revealed the following:<br><br>a. Reported to DHW (Director Of Health and Wellness) that resident had ants in resident's bed...made maintenance aware. He directed DHW to where ant spray was and the room/bathroom was sprayed.<br>b. Reported to DHW that more ants were observed in the resident's room again. Resident's room was cleaned again and sprayed. Resident was moved to a different room...Maintenance Director made aware again. Pest control to come out and do room to room treatments.<br><br>It is unknown why the pest control companies' treatments were not effective, and why there was repeated treatments of the same nature as the solution for preventing the ants' entry. Since there was no documented grievance from Resident #3's representative, there was no response required to be implemented and recorded in the Grievance Log.<br><br>2. Resident #2 filed a complaint with the Administrator and Regional Executive Director on indicating he had not received a medication. Review of the Customer Service Grievance & Resolution Form dated revealed the pharmacy was called and it was determined that the pharmacy had not filled the medication because of their need to clarify with the prescribing health care provider his/her approval to take the medication with another that the resident was taking due to possible negative interactions. The grievance was marked with the answer "no" for the inquiry as to whether or not it was resolved. | A 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 10<br><br>Review of the Medication Observation Record (MOR) for , and shows the resident did not receive , to be taken twice daily, from (evening dose) through (morning dose). The auto generated explanation for most of these doses not being given was noted as "Medication not available" or "Other-reordered". There was no observation note or any follow up documented in the resident's record showing that the facility had sent the refill request to the appropriate pharmacy and/or health care provider, or had called to find out why the medication was not delivered. There was no documentation showing the facility was making every reasonable effort to obtain a refill of the medication until when the resident brought it to the Adminstrator's attention.<br><br>On at 11:42 AM, a pharmacy representative stated during interview that the resident's could not be filled when the facility sent the original admission list of medications when the resident was admitted on because it had recently been filled and picked up, and was not due yet for refill. They explained that if a medication is not able to be filled initially when they receive the list for new admissions, it is not automatically put on the "cycle" which would ensure it to be filled automatically and delivered to the facility.<br><br>It was not investigated or explained in writing and provided to the resident within 7 days as a resolution to the grievance how the medications for new residents will be confirmed as on the "cycled medications" to prevent recurrence of a medication not refilled automatically. There was no procedure put in place as a resolution to the grievance that would require staff at the facility to follow up on medications that were not available | A 030 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 030 | Continued From page 11<br><br>to find out how the refills could be obtained depending on what the issue was, such as a phone call to the pharmacy when a medication was not available. If a procedure was in place, this medication would have been filled much sooner than , 11 days after the supply ran out.<br><br>It was evident that the grievances, when documented, had resolutions that did not prevent recurrence of the same issues brought to the facility's attention. These findings were discussed with the Administrator and Regional Executive Director on at 2:00 PM. The facility provided no additional information for review at this time.<br><br>Class III | A 030 | | |
| A 054 | 59A-36.008(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(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.<br>(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:<br>1. The name of the resident and any known | A 054 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 12<br><br>the resident may have;<br>2. The name of the resident's health care provider and the health care provider's telephone number;<br>3. The name, strength, and directions for use of each medication; and,<br>4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.<br>(c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review, it was determined the facility failed to ensure the Medication Observation Record (MOR) was accurate for 1 out of 3 sampled residents (Resident #2) who required assistance with the self-administration of medication.<br><br>The findings included:<br><br>During review of the , and MOR's for Resident #2, the following errors were identified:<br><br>a. The resident did not receive , to be taken twice daily, from (evening dose) through (morning dose). The medication was marked as "Medication not available" or "Other-reordered".<br>b. Two different staff members intialed that the medication was given on in the morning and on in the morning, when the medication was not available.<br><br>These findings were discussed with the | A 054 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 13<br><br>Administrator and Regional Executive Director on at 2:00 PM. The facility provided no additional information for review at this time.<br><br>Class III | A 054 | | |
| A 056 | 59A-36.008(7) FAC Medication - Labeling and Orders<br><br>(7) MEDICATION LABELING AND ORDERS.<br>(a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:<br>1. The resident's name; and,<br>2. The identification of each medicinal drug in the container.<br>(b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another.<br>(c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff | A 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 056 | Continued From page 14<br>who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.<br>(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.<br>(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.<br>(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.<br>(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a | A 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 056 | Continued From page 15<br><br>label containing the following:<br>1. Practitioner's name,<br>2. Resident's name,<br>3. Date dispensed,<br>4. Name and strength of the drug,<br>5. Directions for use; and,<br>6. Expiration date.<br>(h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and an interview, it was determined that the facility failed to make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner for 1 out of 3 sampled residents (Resident #2).<br><br>The findings included:<br><br>Resident #2 filed a complaint with the Administrator on indicating that he had not received a medication. Review of the Customer Service Grievance & Resolution Form dated revealed the pharmacy was called and it was determined that the pharmacy had not filled the medication because of their need to clarify with the prescribing health care provider his/her approval to take the medication with another that the resident was taking due to possible negative interactions.<br><br>Review of the Medication Observation Record | A 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 056 | Continued From page 16<br><br>(MOR) for , and shows the resident did not receive , to be taken twice daily, from (evening dose) through (morning dose). The automatically generated explanation for most of these doses not being given was noted as "Medication not available" or "Other-reordered". There was no observation note or any follow up documented in the resident's record showing that the facility had sent the refill request to the appropriate pharmacy and/or health care provider, or had called to find out why the medication was not delivered. There was no documentation showing the facility was making every reasonable effort to obtain a refill of the medication until when the resident brought it to the Adminstrator's attention.<br><br>On at 12:30 PM, a pharmacy representative stated during interview that the resident's could not be filled when the facility sent the original list of medications when the resident was admitted on because it had recently been filled and picked up, and was not due yet for a refill. He explained that if a medication is not able to be filled initially when they receive the list for new admissions, it is not automatically put on the "cycle" which would ensure it to be filled automatically and delivered to the facility.<br><br>There was no procedure in place to ensure medications for new residents will be confirmed as on the "cycled medications" to prevent recurrence of a medication not refilled automatically. There was no procedure put in place that would require staff at the facility to follow up on medications that were not available to find out how the refills could be obtained depending on what the issue was, such as a phone call to the pharmacy when a medication | A 056 | | |

Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11965169 | A. BUILDING: _____ B. WING _____ | 10/13/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WICKSHIRE PORT ST LUCIE | 9825 S. U.S. HIGHWAY 1 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 056 | Continued From page 17<br><br>was not available. If a procedure was in place, this medication would have been filled much sooner than , 11 days after the supply ran out.<br><br>These findings were discussed with the Administrator and Regional Executive Director on at 2:00 PM. The facility provided no additional information for review at this time.<br><br>Class III | A 056 | | |