

Agency for Health Care Administration

|                                                        |                                                                                                                                                                                         |                                                                                                |                                                                                                                          |  |                                                        |
|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION    |                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969544</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/27/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GRACE MANOR</b> |                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>221 SW YAGER PL<br/>PORT SAINT LUCIE, FL 34953</b> |                                                                                                                          |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                            | ID<br>PREFIX<br>TAG                                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                  | Initial Comments<br><br>An unannounced Relicensure and Generator Monitoring survey was conducted at Grace Manor on 10/27/25. The provider had no deficiencies at the time of the visit. | A 000                                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE