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 _____	01/21/2026

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 An unannounced Complaint (#2026000652) and a Generator Monitoring survey were conducted on at Wickshire Port St. Lucie. The facility had a deficiency related to the Complaint identified at the time of the visit.	A 000		
A 050	429.256(2&6) FS;59A-36.008(1) FAC Medication - Self Administered Medications 429.256 (2) Residents who are capable of self-administering their own medications and performing other tasks without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. An unlicensed person may also provide assistance with other tasks specified in subsection (6). Assistance with self-administration of medication or such other tasks by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, , dosage forms, patches, and , , , , and dosage forms including solutions, suspensions, sprays, and inhalers. (6) Assistance with other tasks includes: (a) Assisting with the use of a to perform - level checks.	A 050		

AHCA Form 3020-0001

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

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A 050	Continued From page 1 (b) Assisting with putting on and taking off stockings. (c) Assisting with applying and removing an , , , but not with titrating the prescribed , , settings. (d) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (e) Assisting with measuring vital signs. (f) Assisting with , bags. 59A-36.008 Pursuant to sections 429.255 and 429.256, F.S., and this rule, licensed facilities may assist with the self-administration or administration of medications to residents in a facility. A resident may not be compelled to take medications but may be counseled in accordance with this rule. (1) SELF ADMINISTERED MEDICATIONS. (a) Residents who are capable of self-administering their medications without assistance must be encouraged and allowed to do so. (b) If facility staff observes health changes that could reasonably be attributed to the improper self-administration of medication, staff must consult with the resident concerning any problems the resident may be experiencing in self-administering the medications. The consultation should describe the services offered by the facility that aid the resident with medication administration through the use of a pill organizer, through providing assistance with self-administration of medications, or through administering medications. The facility must contact the resident's health care provider when observable health changes occur that may be attributed to the resident's medications. The facility must document such contacts in the	A 050		

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A 050	Continued From page 2 resident's records. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure orders received by a health care provider were followed for 2 of 4 sampled residents (Resident #1 and #5). The findings included: On , the Medication Observation Records (MORs) showing the time that assistance with self-administration of medication was provided to Residents #1 and #5 were reviewed. The following discrepancies were identified. 1. Resident #1's prescribed medications and documented times of assistance provided: a. was to be given at 5:00 PM but was received at 8:28 PM on . This medication is prescribed to be "given with dinner". b. , was to be given at 12:00 PM but was received at 1:15 PM on . c. Oxybutinin and were to be given at 9:00 PM but were received at 10:37 PM on . d. , was to be given at 12:00 PM but was received at 2:20 PM on . e. Oxybutinin was to be given at 8:00 PM but was received at 9:11 PM on . f. , and were supposed to be given at 7:30 AM but were received at 9:03 AM on . This medication is prescribed to be "given before breakfast" (as of for). g. , and were supposed to be given at 7:30 AM but were received at 8:36	A 050		

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A 050	Continued From page 3 AM on . These medications are prescribed to be "given before breakfast" (as of for). h. Oxybutinin was to be given at 8:00 PM but was received at 9:12 PM on . During a telephonic interview with the pharmacy representative on at 3:45 PM, she stated that Resident #1 was prescribed , ( ) on by a third party , , health care provider (HCP) and that the medication was delivered to the facility on . An email to the facility's Administrator from the pharmacy representative on at 4:35 PM notes the medication was returned to the pharmacy. Review of the resident's record showed another order signed by the resident's primary HCP on indicating the resident was to receive Clonezepam .5 milligrams (mg) and , .5 milligrams (mg). However, neither of these medications were given to the resident as evidenced by their absence on the and MORs. The Clonezepam was not started again until . An observation note dated written by the previous Wellness and Director of Resident Services states that she called the pharmacy "to find out when Clonezepam was initiated/discontinued...due to ordering , ". There was no investigation into why neither was listed on the MOR or what happened to the order for both dated , or why , was returned when there were two different orders (and) for it to be given to the resident. Review of the discontinued orders for this resident on revealed no discontinue order for Clonezepam .5 mg or , dated after . 2. Resident #5's prescribed medications and	A 050		

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A 050	Continued From page 4 documented times of assistance provided: a. Accu-check for ˘ testing and ˘ were supposed to be provided before dinner at 4:30 PM daily, but assistance was given at 6:32 PM on , 7:34 PM on and 5:34 PM on . b. Accu-check for ˘ testing and ˘ were supposed to be provided before breakfast at 7:30 AM daily, but assistance was given at 9:23 AM on , 8:36 AM on , 9:05 AM on , 9:17 AM on and 9:22 AM on . Review of the dining times scheduled for residents at the facility revealed the posted times outside the dining room were 7:30 AM through 9:00 AM for breakfast, 11:30 AM through 1:00 PM for lunch, and 4:30 PM through 6:00 PM for dinner. During a telephonic interview with Resident #5's representative on at 2:27 PM, the representative acknowledged there was concern about the timing of the as the resident's ˘ levels were not maintained within desired ranges with the current provision. The acceptable standard of practice when providing medication at designated times listed on the MORs is that the recipient receives the medication within one (1) hour before the allotted time, or within one (1) hour after the noted time. If the prescription indicates the recipient is to have ˘ testing before meals, the test may present inaccurate findings if done during or after a meal. The Administrator was notified of these findings on at 5:00 PM. The facility provided no	A 050		

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A 050	Continued From page 5 additional information for review at this time. Class III	A 050		