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
	AL11910733	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING VILLAGE OF MARGATE	6810 SW 7TH STREET MARGATE, FL 33068

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A 000	Initial Comments AMENDED REPORT An unannounced Relicensure (CHOW), Complaint (#2021001897, #2021007227, #2021007632 and #2022008609) and Generator Monitoring survey was conducted on [redacted] at Caring Village of Margate LLC. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 026	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers,	A 026		

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A 026	Continued From page 1 senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure an ongoing activity program/calendar for a minimum of 12 hours a week and the posting of such calendar in common areas of the facility for all residents to review. The findings included: During a tour of the facility on commencing at 10:06 AM, observations were made of the common areas of the facility. Further observations revealed no evidence of any activity calendars posted for residents to review. On at 1:28 PM, an interview was conducted with Resident #12 who when asked about the facility activity program stated, 'There are no activities.' On at 1:30 PM, an interview was conducted with Resident #10 who when asked about the facility activity program stated, 'They don't do anything anymore.' On at 1:32 PM, an interview was conducted with Resident #13 who also stated regarding activities, 'There are none.'	A 026		

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A 026	Continued From page 2 In an interview conducted with the Administrator on [redacted] at 2:31 PM, she stated residents are always ripping papers off the bulletin board. There was no mention of possibly placing important papers and resident communication, to include an Activity Calendar, behind a glass or plexiglass closed cabinet so residents could not rip the papers off. Further, a request was made to the Administrator for documentation of the breakdown of the required activity schedule. She presented a schedule with days of the week, however review of the schedule revealed it had no breakdown of 12 hours a week. Residents were observed watching television in the common areas however there were no scheduled activities for residents to participate in. No additional documentation was provided during the survey. On [redacted] at 5:02 PM, during the exit conference conducted with the Administrator, she was informed of and acknowledged the findings. Class III	A 026		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar	A 032		

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A 032	Continued From page 3 days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including	A 032		

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A 032	Continued From page 4 specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that all direct care staff participated in resident Elopement Drills at least twice annually. The findings included: Review of the facility Elopement Drills Log revealed on ..... an elopement drill was conducted with only 9 direct care staff members who participated from all 3 working shifts. No other elopement drills were available for review for 2022. Further review of the Elopement Drills Log revealed on , only 9 of 43 direct care staff participated from all 3 shifts in the elopement drill. No other elopement drill documentation was available for review. In an interview conducted with the Administrator on at 3:222 PM, she stated she does not conduct the elopement drills, the facility Manager does. She further stated she only signs off on the Elopement Drill form and she was not aware that all direct care staff members had to	A 032		

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A 032	Continued From page 5 participate twice annually. No additional documentation was provided during the survey. Class III	A 032		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an . . syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's . . or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying . , medications. (e) Returning the medication container to proper storage.	A 052		

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A 052	Continued From page 6 (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.	A 052		

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A 052	Continued From page 7 (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to	A 052		

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A 052	Continued From page 8 enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff who assist residents with the self-administration of medications ensure the medications are confirmed and signed off at the time of administration; and the medication cart is secure during the medication administration process for 3 of 5 residents observed receiving assistance	A 052		

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A 052	Continued From page 9 with the self-administration of medications, specifically Resident #5, Resident #6 and Resident #7. The findings included: 1) On [redacted] at 11:58 AM, Medication Technician (MT) Staff C was observed to assist Resident #5 with the administration of [redacted] 500 milligrams (mg) one tablet. MT Staff C failed to lock her medication cart as she walked over to assist the resident with her medication. Further, MT Staff C failed to sign off on the Medication Observation Record (MOR) after the medication was given. 2) On [redacted] at 12:02 PM, MT Staff C was observed to open the medication cart drawer and retrieve a dose of [redacted] 10 mg and [redacted] 10 mg from the cart and proceeded to go to Resident #6 without checking the MOR or matching the medications she retrieved to the MOR. An inquiry was made at the time to MT Staff C how she knew what medication to give to Resident #6 to which she stated, 'I just know.' Further, MT Staff C failed to sign off on the MOR after the medication was given. Additionally, MT Staff C failed to lock the medication cart as she was assisting the resident with his medications. 3) On [redacted] at 12:04 PM, MT Staff C was observed to open the medication cart drawer and retrieve 2 tablets of [redacted] 325 mg from the medication cart and proceeded to go to Resident #7 without checking the MOR or matching the medication she retrieved to the MOR. An inquiry was made at the time to MT Staff C how she knew what medication to give to Resident #7 to which she stated, 'I just know.' Further, MT Staff C failed to sign off on the MOR	A 052		

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A 052	Continued From page 10 after the medication was given. Additionally, MT Staff C failed to lock the medication cart as she was assisting the resident with her medications. Class III	A 052		
A 086	59A-36.011(10) FAC Training - ADRD (10) ..... AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , and , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues.	A 086		

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A 086	Continued From page 11 (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection	A 086		

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A 086	Continued From page 12 (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or 2. Three years of practical experience in a program providing care to persons with or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 086		

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A 086	Continued From page 13 failed to ensure direct care employees received the required and Related (ADRD) Level II training within 9 months of hire for 1 of 2 personnel records reviewed, specifically Staff E. The findings included: Review of the personnel record for Home Health Aide (HHA) Staff E revealed a date of hire of to work the 3:00 PM to 11:00 PM shift to provide direct resident care. Further review of the personnel record revealed no documented evidence that HHA Staff E had completed the additional 4 hours of ADRD training within 9 months of hire as required. On at 4:41 PM, an interview was conducted with the Administrator who acknowledged the finding. Class III	A 086		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910733	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING VILLAGE OF MARGATE	6810 SW 7TH STREET MARGATE, FL 33068

(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 152	Continued From page 14 or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide a safe, clean, and decent living environment for the residents as evidenced by observation of live roach activity and unsanitary environmental conditions. The findings included: On the facility had a census of 98 residents with a capacity of 108 residents. On at 10:06 AM, an initial tour was conducted with the Administrator who stated the	A 152		

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A 152	Continued From page 15 facility is divided into 4 sections. Each section consists of a dining area, lounge area with sofas and recliners and a television. During a tour of the Memory Care Unit, which was Section 4, a request was made to unlock a bathroom door. Upon a staff member unlocking the bathroom door, the bathroom floor and sink were observed with live roaches present. (Photographic evidence obtained.) Further observation was made of 16 leather-like recliners used by residents, with 7 of them being extremely worn with peeling material with sharp edges. (Photographic evidence obtained.) On at 10:14 AM, a walk-through observation was conducted of the facility kitchen which prepares and serves residents meals. Observed under the preparation table and inside the food storage pantry room were live roaches present. (Photographic evidence obtained.) At this time, an interview was conducted with the Kitchen Manager who acknowledged the finding and stated the pest control service will take care of the problem. On at 11:21 AM, a tour of Section 1 located on the far east side of the building was conducted with the Administrator. Entering through the door which had code access, a strong mildew like and like odor was present. 7 residents were observed sitting in a room with tables and chairs watching television with the majority of the residents present without shoes on, only wearing socks with holes in them. At this time, a live roach was observed crawling on a resident who was seated in a recliner which had a dried substance on it which looked like feces. In an observation conducted with the	A 152		

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A 152	Continued From page 16 Administrator on [redacted] at 11:29 AM, observation was made of a chair with a dried feces like looking substance on the chair which was located near the door leading to the covered area on the east side of the facility. In an interview conducted with the Administrator at this time, she stated she was unsure what the substance was but would have housekeeping address it. The feces like substance was never cleaned up during the remainder of the survey. In an interview conducted with the Administrator on [redacted] at approximately 11:30 AM, she acknowledged and confirmed the facility had roaches. She further stated they have an active contract with a pest control vendor. A request was made to review the pest control contracts. Review of the facility's Pest Control Agreement dated [redacted], which was dated and signed by the Administrator, documented the agreement treats ants, roaches, silverfish, earwigs and spiders. Further review of the document in the folder revealed 3 treatments by the company dated [redacted], with the last service date of [redacted]. No additional or current treatment documents from the pest control company were provided during the survey, indicating the last time the facility was treated for roaches was in [redacted], of 2023. On [redacted] at 3:22 PM, a follow up interview was conducted with the Administrator who acknowledged the roach and environmental findings. Class III	A 152		