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
	AL11969268	A. BUILDING: _____ B. WING _____	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL CARE ASSISTED LIVING FACILITY II	4385 FLAX CT PALM BEACH GARDENS, FL 33410

(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, Complaint (#2024001374) and Generator Monitoring survey was conducted on at Emmanuel Care Assisted Living Facility II. The facility had deficiencies 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969268	A. BUILDING: _____ B. WING _____	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL CARE ASSISTED LIVING FACILITY II	4385 FLAX CT PALM BEACH GARDENS, FL 33410

(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 observation and record review Staff A-Caregiver failed to have a current and up to date Medication Observation Report (MOR) for 1 of 4 sampled residents (Resident #4). The findings included: On at 9:30AM a medication audit was conducted with Staff A for Resident #4's medications. The medications was reviewed and it revealed the following medications were not listed on the current MOR dated to 1. - 500mg, Take 2 tabs by 2X daily. 2. -10mg (Aurobindo),Take 1 tab by 1X daily . On at 9:30AM during an interview with Staff A,she stated "yes" she administered the medications to Resident #4 daily as prescribed on the label of the medication bottle. Staff A confirmed she administered the medications today prior to Resident #4 leaving for day care. On at 10:25AM an interview was held with the Administrator and she revealed Staff A advised her she gave the medications as prescribed but the medications are not listed on the MOR. The Administrator stated she will call the pharmacy and request a new and current MOR. She also stated she knows Staff A administered the medications. Only after surveyor interventing on at 10:55AM, the Administrator received a current	A 054		

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
	AL11969268	A. BUILDING: _____ B. WING _____	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMMANUEL CARE ASSISTED LIVING FACILITY II	4385 FLAX CT PALM BEACH GARDENS, FL 33410

(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 2 MOR with the two medications listed 1. 500mg and 2. 10mg. On During an interview at 4:00PM with the Administrator she acknowledge the findings. Class III	A 054		