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 _____	01/22/2025

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 An unannounced Complaint survey, #2025000459, was conducted at Caring Village of Margate on . The provider had deficiencies at the time of the visit.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interviews, and records review, it was determined that the facility failed to provide adequate supervision to prevent 2 of 2 sample residents (Resident #1 & Resident #2) from eloping. The findings included: On , a little after lunch, Residents #1 and Residents #2 along with some other residents were left unsupervised on the patio of section 1 area, smoking, as reported by Staff B, a Certified Nursing Assistant. The area is secured and fenced from the ground up to the ceiling. Despite this security measures in place, lack of	A 025		

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A 025	Continued From page 2 residents' monitoring afforded one of the residents ample time to become highly creative by unlacing the metal fence links and thereby creating a large enough opening to escape from the facility. As a result, two of the residents (Resident #1 & #2) left the facility. Resident #1 was found a few hours later about three miles East of the facility and was brought to the facility with police assistance, after much resistance and aggression by him. However, Resident #2 returned by himself five days later, uninjured. Interviews conducted with Employee A, a Medical Technician (Med Tech), on at 11:27 AM, revealed she has been working at this facility since , . She usually works in sections 3 and 4 of the facility. Employee A informed that there were two med Techs at the facility (she and another med Tech) with two Certified Nursing Assistant/Home Health Aide (CNA/HHA), in each section of the facility. There are four sections in the facility. Employee A recalled it was a little bit after 1:00 PM or about 1:20 PM when she saw Staff B and C frantically or in panic mode trying to explain to the other Med Tech that two residents had left the facility. Employee A said she could not understand at first what was going on. So, she went to Section1 where the Aides were working at to inquire. Staff A said she found out that Resident #1 and Resident #2 had escaped the facility. She immediately went to the emergency door to see if they were walking up the street, they did not see them. Employee A said she came and contacted the Administrator by phone and explained to him what had happened. She was told not to leave the area where the residents escaped from. Then, later, as Staff A recalled, two of the Aides	A 025		

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A 025	Continued From page 3 went by car looking for the missing residents. When Resident #1 was located a few miles East down the road, he was aggressive, so they called the Police and reported that Resident #1 who is one of their residents was at the bus stop at the intersection of Southgate and 441 (State Road 7) and was physically threatening to staff. After two police officers showed up, they were able to convince Resident #1, to go to the facility with them. Thereafter, the Police officers requested information about Resident #2 to initiate a missing persone search. However, Resident #2 could not be located. Employee A said, she and all staff knew that whenever residents are left outside, a staff member is supposed to be there watching them. This rule was in place for section 1, 2 and 4 for a long time. But, since section 3 does not have a patio this rule did not apply to them. Employee A said that they had a meeting a few days after the incident, on the 15th of , during which, the Administrator informed all staff to make sure that the residents are supervised at all times whenever they are in the smoking area. Residents cannot be left alone. Employee B, a Home Health Aide (HHA) reported on at 12:01 PM that she was present the day of the elopement incident. Employee B said she was working in section 1 and was one of the staff responsible for supervising the residents. However, she stated that at times, while the residents are smoking, they leave them alone to catch up on their other household responsibilities. Employee B said that she knew that residents are supposed to be monitored at all times while they are in the smoking area of section I. She said no one expected that the residents would be able to	A 025		

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A 025	Continued From page 4 unlace the fence to escape. Employee C, a medical technician reported on at 12:33 PM, she too was aware of the elopement incident. She said that they all knew that Residents cannot be left alone in the patio when they are smoking, or even when they simply are in the area. She said it was human error. Employee D a home health Aide confirmed on at 2:01 PM, that all staff knew very well that the resident require supervision when they are in the patio. Employee D said some of the residents are very "slick". They can easily take advantage when staff let their "guard down". Employee D acknowledged that this incident was a mistake ..."human makes mistakes", Employee D added. Review of Resident #1's health Assessment (AHCA form 1823) dated , and the Sheet revealed an admission date of . The documented diagnoses are: ; ; ; ; . AOX3(alert and oriented x3), Calm, and . This new 1823 documented Resident #1 is at risk for elopement. The initial 1823 documented that Resident #1 was not at risk for elopement and dated . Resident #1 is independent with all activities of daily living and only required assistance with self-administration of medication and supervision. Resident #2 reported on at 1:49 PM, that he was outside with Resident #1. When he saw the fence was opened, he thought that it was "free for all to escape from here". He wanted to go home to see if his brother was okay. He said when he left him, he was on the floor , so he wanted to go to find out how he was	A 025		

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A 025	Continued From page 5 doing. He kept asking them to leave, they did not want him to go. Resident #2 Sheet documented he was admitted to the facility on . His diagnoses included: Right Angle or Right ˏ - with lense, , . His health assessment dated documented he was at risk for elopement, but independent with all activities of daily living (ADL). During the exit meeting with the Administrator on at 3:00 PM, the findings were discussed and the Administrator acknowledged the findings. Class III	A 025		
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	A 052		

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A 052	Continued From page 6 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. (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.	A 052		

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A 052	Continued From page 7 (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. (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 , ⌄ 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	A 052		

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A 052	Continued From page 8 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 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.	A 052		

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A 052	Continued From page 9 (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 records review, interviews, and observation, it was determined that the facility failed to ensure that 1 of 1 sample resident (Resident #1) received assistance for self-administration of medications, as ordered by the physician. The findings included: On at 12:58 PM, review of Resident #1's Medication Observation Record (MOR) revealed missing signatures for prescribed medications that were supposed to be administered during the morning of at 8:00 AM. An interview conducted with Staff A, a Medical Technician who was present during the review of the MOR on at 12:58 PM. The Medical Technician said that when she went to the resident's room, he told her to get out of the room. However, there was no notes on the MOR to reflect or indicate that Resident #1 had refused his morning medications. She did not document it anywhere. Review of the medication package showed the medications , 50 mg were to be taken twice a day in the morning and before bedtime, and , 5 mg 1 tablet was to be administered every morning. At 1:12 PM, when Staff A went to give Resident #1 the missing medications, Resident #1 was observed to be very polite, compliant and thankful	A 052		

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A 052	Continued From page 10 for the medications. Resident #1 did not exhibit any resistance, and did not show any reluctance in taking his medications. Instead, Resident #1 inquired about the medications he was being given and wanted to know what they were. In a follow-up interview with Resident #1, in his room, on at 1:26 PM, Resident #1 stated that he did not refuse to take his medications. Resident #1 said they were not given to him. Review of Resident #1's health assessment (AHCA Form 1823) dated documented the following diagnoses: , ; , ; , ; , ; and . Resident #1 is noted to be alert and oriented x 3 (AOX3), Calm and , . The 1823 documented that Resident #1 was at risk for elopement. The resident was prescribed the medication , 50 mg tablet and ordered to take 1 tablet by in the morning and 1 tablet before bedtime. The findings were discussed with Staff A who agreed, and the Administrator who acknowledge them during the exit meeting on at about 3:00 PM. Class III	A 052		
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	A 054		

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A 054	Continued From page 11 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 physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure that the medication observation record (MOR) was documented after assisting residents with self-administration of medicaitons. This was evident in 8 of 9 sample residents' MORs reviewed (Resident #1; Resident #3, Resident #4; Resident #5, Resident #6, Resident #7, Resident #8, and Resident #) who required assistance with self-administration of medications. . The findings included:	A 054		

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A 054	Continued From page 12 Resident #1 was admitted to the facility on . The health assessment AHCA form 1823 dated documented the following diagnoses: , ; , ; , , ; and . Resident #1 was alert and oriented (AOX3). Resident #1 was noted to be calm, , . Resident #1 required assistance with self-administration of medications and was prescribed: , 50 mg tablet which were to be taken 1 tablet by in the morning and 1 tablet before bedtime and Alprazalam. On at 12:58 PM, while reviewing the resident's Medication Observation Record (MOR), it was noted that the MOR was not signed to reflect that the morning medications were administered as ordered. The signature slot was left blank. In addition, the electronic MOR was flashing a warning message "Overdue" to bring awareness to the fact that the MOR was not signed or the medication was not yet given. In an interview conducted with Employee A, a Medical Technician, on at approximately 1:00 PM , Employee A claimed that when she went to the resident's room to assist him with taking his medication, Resident #1 told her to get out of the room. However, there was no evidence of that refusal documented anywhere. Review of the medication cart and packages showed Resident #1 had two medications to take in the morning. , 50 mg was to be taken twice a day 8:00 AM and 8:00 PM, and . 5 mg 1 tablet was supposed to be given in the morning 8:00 AM. Review of the medication cart showed that the medication were in fact not administered. The dosages in the prepackaged plastic container were still intact in	A 054		

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A 054	Continued From page 13 the bag. Resident #1 informed on at 1:26 PM, that he had no major problems with the facility. He voiced some minor concerns, but stated he did not refuse to take his medications. In fact, when Employee A approached Resident #1 to give him his morning medications at 1:12 PM, Resident #1 was very compliant with taking his medications. Resident #1 simply thanked Employee A for bringing the medications. Further review of the MOR revealed there were more missing signatures on the days and times medications were to be administered. The electronic MOR highlighted that some medications were two days overdue. The Residents affected by this identified issue were briefly interviewed on from 2:07 PM to 2:20 PM, to identify the extent of the situation and if they had received their medications. All the residents claimed to have received their medications. Resident #3 said everything was okay. He does receive his medications. He believed that they always give him his medication. The missing signature was for the medication 100 mg tablet. take 1 tablet by every (Q) 12 hours. It was 20 hrs, overdue. Resident #4 said she received her medication all the time. She had no concerns. Review of the MOR showed she was supposed to take , , , 30 mg once daily. The medication was 20 hrs. overdue. Resident #5 said he always gets his medications. He had no complaints. His diagnoses from the AHCA form 1823 included Fibrilation,	A 054		

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 _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 054	Continued From page 14 ( ) type 2; , ; Paranoia; and Partheno's . He was admitted on . He required assistance with self-administration of medications. The medication not signed for was IPrat- 0.5 -3 (2.5) mg/3 ML. inhale 1 vial via Q 8 hrs. The medication was 23 hours overdue. Resident #6 diagnoses included: ( ) Type 2; ; and , retreived from the health assessment dated . He was admitted to the facility on . He had no complaints. He said he gets his medication on time. The prescribed medication, as per the MOR was 10 gm/ML solution. Take 30 ML by two times a day. The medication was 12 hours overdue_no signature. Resident #7 diagnoses included: , with and , as well as , She was admitted to the facility on . She was able to self-administer her medications, as per the health assessment form 1823. Resident #7's MOR was not signed and noted overdue for 12 and 14 hours. Resident #8 diagnoses included: Gait ; ; : , ; , ; and Severe , . She said she always gets her medication. Her admission date to the facility was on as the Sheet. Resident #8's prescribed medications were Praprodolol 10 mg tablet. Take 1 tablet by every 8 hours, and , 1 mg tablet. The MOR was not signed for 14 hours. The findings were discussed with the	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
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A 054	Continued From page 15 Administrator on at 3:06 PM, and he said, he will ensure that those issues are addressed and corrected. Class III	A 054		