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
	AL11912046	A. BUILDING: _____ B. WING _____	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORAL PLAZA ALF	5850 MARGATE BLVD. MARGATE, FL 33063

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A 000	Initial Comments An unannounced Complaint investigation, complaint #2026005884, was conducted at Coral Plaza ALF from - . The facility had deficiencies at the time of the survey.	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 observation, interview and record review, the facility failed to provide care and services appropriate to meet the needs of the resident. As evidenced by the failure to ensure staff responded to a significant change in condition for 1 of 1 sampled residents, (Resident #1) which resulted in the resident transfer to higher level of care for evaluation of potentially life threatening symptom. The findings include: On at approximately 10:15 AM Resident #1 was observed in bed. The resident was utilizing ,,, ( ) via a	A 025		

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A 025	Continued From page 2 which was attached to the bedside concentrator device. Resident #1 was alert and oriented and stated she had recently been sent to the hospital since she was "not feeling well". The resident stated that she returned to the facility the same night and now requires continuously to assist her to breathe. The resident stated that she has hospice services for diagnosis of ( ). Review of Resident#1 medical record indicated the resident was admitted to the facility on from home and was receiving hospice services for /Centrilobular and . Review of Resident #1's Resident Health Assessment form 1823 dated indicated the resident was alert and oriented, was non-ambulatory requiring use of a wheelchair for mobility, and required assistance with Activities of Daily Living (ADL). Review of Resident #1's medical record indicated on 12:30 a physician order was written for 100 mg every day and , 10 mg twice daily for control. Review of Resident #1's progress notes indicated on at 9:30 AM the Licensed Practical Nurse (LPN) was notified to go to the resident's room, the nurse found the resident lying in bed and unresponsive. Vital signs were taken; , 128/ 60, , saturation reading was 88% on room air. The nurse tests the resident's which measures 28 mg/dL. [Reference: Centers for Control and Prevention (CDC) website indicates when drops below 55 mg/dL, it's considered severely low. Low	A 025		

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A 025	Continued From page 3	A 025		

sugar, also known as , can be very dangerous.] The nurse applies at 2 L and places sugar under Resident #1's . The nurse documents she notified hospice of the resident's condition, and she was informed the hospice nurse would come to assess the resident. The note further indicates the hospice nurse arrives at 10 AM and assesses the resident with no new orders or treatment written.

In an interview with the Hospice Nurse Manager on at 4:14 PM, she stated a call was received on that Resident #1 was . She stated the hospice nurse arrived to assess Resident#1 and finds her alert and responsive. The nurse notifies the physician of her findings. The Hospice Nurse Manager states no further orders were written. She stated that hospice doesn't manage monitoring checks, if symptoms develop then the facility should notify hospice. The nurse found no symptoms to manage, and she informed the facility she would be making a daily visit for next few days. The Hospice Nurse Manager stated the facility was informed that the resident was considered "imminent" medical status yet 24-hour emergency crisis care was not ordered at that time. The Hospice Nurse Manager stated that facility staff had not notified the provider prior to transferring Resident #1 to the hospital 911 emergency during the evening on . The Hospice Nurse Manager stated that medications were ordered after the resident went to a surgery and elevated levels were identified.

Review of Resident #1's facility progress note on 7 AM indicated that a report was received from previous shift 3-11pm that Resident#1 was in bed, breathing, but unresponsive to verbal and

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A 025	Continued From page 4 stimulation. 911 was called to transfer the resident to the hospital for evaluation. Review of Resident #1's progress note on 9:30 AM indicates the Resident #1 returned to the facility at 5:20 AM. Resident#1 was alert, verbally responsive, and had no acute distress noted. Review of Resident #1's hospital records dated indicated the resident was received with . The resident was breathing and had a , . The resident was covered in sweat and had a strong odor of . level reading in the emergency room was 30 mg/dL. Resident #1 was administered fluids which improved her responsiveness. The notes indicated that the facility had issues providing complete medical information promptly for review. The note further indicates that Resident#1 stated she felt better with treatment, she had not eaten dinner and felt possibly due to low . Discharge orders date indicated recommending holding and , until physician can reassess medications and every 2-hour checks throughout evening and day until stabilized. Review of Resident #1's progress note on 1 PM indicates the resident is seen by the hospice physician who writes order to hold , and . The physician orders Home Health nursing to perform monitoring twice a day for 7 days and report results directly to the physician. Resident#1 is placed on hospice 24 Crisis Care for further observation. In an interview with Staff #A on at 2:30	A 025		

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A 025	Continued From page 5 PM, she started she came on duty on at 5 PM and went to check on Resident #1 around 5:20 PM,and she found the resident asleep. Staff #A stated she went to Resident#1's room and found she had not eaten any of her dinner meal and was still asleep. Staff #A stated that Resident #1 is usually awake and alert. Staff #A stated that she made rounds every hour to check on the resident and continued to find her asleep. Staff #A stated she attempted to wake Resident #1 to provide evening care and found her to be very ˵ and she didn't respond to verbal stimuli. Staff #A stated she went to inform Staff #C and #D about her concerns with Resident #1 and was met with "shrugged " and with no response to her concerns. She stated she knew "something was wrong with Resident #1". Review of the facility staffing schedule for PM shift indicated Staff #B, #C and #D were assigned to manage any resident concerns for the PM shift. Staff #A stated she did not call the Director of Nursing (DON) or Administrator to report her concerns. She stated she was very concerned about Resident #1's ˵, and unresponsiveness and called 911 herself. She stated she did not call the Hospice Nurse prior to the 911 call. Staff #A stated that she didn't call DON, since she didn't want to bother her during off hours. In an interview with Staff #B on 2:55 PM, she stated that she was assigned to provide medications to Resident #1 on 3 PM- 11 PM. She stated she was aware that Resident #1 had experienced low ˵ and ˵, earlier that day yet found Resident#1 to be alert and oriented as usual on her shift. She also stated she assisted Resident#1 with her prescribed medications: , 0.5 mg by at 4:57 PM; , 300 mg by	A 025		

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A 025	Continued From page 6	A 025		

and , 10 mg by at 5 PM; 10 mg and -S 8.6 mg -50 mg were administered around 8 PM. Staff #B stated Resident#1 was awake and able to take her medications by . Staff #B stated she was not alerted of any concerns about the resident's status from Staff #A. Staff #B stated she was on her way out of the facility at end of her shift when she saw police and 911 personnel attending to Resident #1.

In an interview with Staff # C on at 4:03 PM she stated she worked the 3p-11p shift on . She stated she was not assigned to assist Resident#1 with medications but had received report that the resident had an episode of low on prior shift. She stated she was aware of instruction by the DON to monitor the resident. Staff #C stated she was not alerted by any staff with concerns/ change in condition about Resident #1.

In an interview with Staff #D on at 4:09 PM, she stated she worked 3p-11p shift on . She stated she was assigned residents on the 2nd floor and had no contact with any residents on the first floor. She stated she was unaware of any change in condition of Resident#1 and had no care staff approached her with concerns about the resident.

In an interview with the Director of Nursing (DON) on at 11:06 AM, she stated Resident #1 was sent to the hospital on for evaluation of . And returned to the facility on at 5:20 AM with discharge orders to hold medications until further evaluation by the health care provider. The DON stated that the facility does not perform routine checks for

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A 025	Continued From page 7 residents. She stated residents requiring and checks must contract with a Home Health Agency to perform that nursing task. The DON stated that hospice residents do not have checks routinely ordered. The DON stated that Resident #1's medications were initially ordered when the resident was preparing for outpatient surgery and was found to have elevated levels. The DON stated that the hospice provider ordered the medications on . The DON stated that she was notified on that Resident #1's level was very low, and the Hospice Nurse was on site with no new orders written. She stated Resident#1 ate her lunch and remained stable in afternoon on with no symptoms. The DON stated she left the facility on at around 7 PM and instructed care staff to "keep an on Resident #1" to monitor the resident. She stated that she did not hear any concerns from staff until she received call on approximately 1 AM from staff stating Resident#1 was sent out to the hospital for a change in condition. The DON stated that Staff #A found Resident#1 and unresponsive, and she called 911. The DON stated that facility staff didn't call hospice prior to the 911 call. The DON stated facility policy for transferring hospice residents is to first call the hospice nurse to receive instructions for transfer. The DON stated that staff should have also call her or the Administrator when a resident is being transferred to the hospital. The DON stated that an unlicensed staff is in charge during evening and nights and have the responsible for assessing a resident for any concerns and call 911. When asked what her expectations were if an unlicensed staff on duty is informed about any resident concerns, or change in condition from care staff, the DON stated she would expect the	A 025		

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A 025	Continued From page 8 designated staff to immediately go check the resident, measure vital signs and call 911 if necessary. She stated she returned to work the next day, , and was informed about the specifics of the transfer. The DON stated that the LPN upon her arrival to work on at 7 AM received report about Resident #1's transfer and the LPN reviewed the hospital discharge orders. The LPN removed Resident #1's medications from the medication cart to prevent the assigned day shift unlicensed staff from giving medications to the resident. (See A54 for specific details related to medication documentation concerns). Review of Resident #1's hospital records dated indicated the resident was received with . The resident was breathing and had a , . The resident was covered in sweat and had a strong odor of . level reading was 30 mg/dL. Resident #1 was administered fluids which improved her responsiveness. The notes indicated that the facility had issues providing complete medical information promptly. The note further indicates that the resident stated she felt better with treatment, she had not eaten dinner,felt possibly due to low . Discharge orders date indicated recommending holding and , until physician can reassess medications and every 2 hour checks throughout evening and day until stabilized. Review of Resident #1's medical record indicated no monitoring until ordered on and began on . Class III	A 025		

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A 054	Continued From page 9	A 054		
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 [illegible] 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 [illegible], 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 interview and record review, the facility failed to ensure an accurate daily medication observation record (MOR) for residents. This was	A 054		

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A 054	Continued From page 10	A 054		

evidenced by the failure of the unlicensed staff to accurately document the prescribed medications that were administered on the MOR, for 1 of 1 sampled residents (Resident #1).

The findings include:

Review of Resident #1's Medication Observation Record (MOR) for , revealed the resident was prescribed , 10 mg by once a day and Junuvia 100 mg by twice a day. Further review of the MOR indicated that Resident #1 was assisted with self-administration of both medications on at 9 AM by unlicensed staff #D.

In an interview with the Director of Nursing (DON) on at 11:35 AM she stated that Resident #1 had been sent to the hospital for evaluation of on . The resident returned to the facility on at 5:20 AM with discharge orders to hold medications until further evaluation by health care provider. The DON stated that the LPN on duty on based on review of discharge orders from the hospital emergency room visit, she removed the medications from the designated medication cart to prevent the unlicensed staff from administering the medication until the healthcare provider made a visit to evaluate Resident #1. The DON stated that Staff #E did not administer prescribed , and Junuvia but had erroneously checked on the electronic medical record (EMOR) that she had. The DON stated that she was unaware that Staff #E had mistakenly documented medication as given on the MOR. The DON stated that Staff #E should have come to her with the occurrence, but Staff #E did not. In a follow-up interview on at

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A 054	Continued From page 11 approximately 11:34 AM the DON stated that Staff #E acknowledges her failure to contact the DON to address the documentation mistake. Class III	A 054		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills	A 084		

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A 084	Continued From page 12 necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and . . , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with	A 084		

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A 084	Continued From page 13 and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required	A 084		

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	AL11912046	A. BUILDING: _____ B. WING _____	04/16/2026

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A 084	Continued From page 14 annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility placed residents at risk by failing to ensure care staff follow training for assistance with self-administration of medications and safe medication practices. This was evidenced by the failure of unlicensed staff to follow guidelines for assistance with self-administration of medications for 1 of 1 sampled residents, (Resident #1). The findings include: Review of Resident #1's Medication Observation Record (MOR) for , revealed the resident was prescribed , 10 mg by once a day and Junuvia 100 mg by twice a day. Further review of the MOR indicated that Resident #1 was assisted with self-administration of both medications on at 9 AM by unlicensed Staff #D. In an interview with the Director of Nursing (DON) on at 11:35 AM she stated that Resident #1 had been sent to the hospital for evaluation of on . The resident returned to the facility on at 5:20 AM with discharge orders to hold medications until further evaluation by health care provider. The DON stated that the LPN on duty on based review of discharge orders from the hospital emergency room visit she removed the medications from the designated medication cart to prevent the unlicensed staff from administering the medication until the healthcare provider made a visit to evaluate Resident #1. The DON stated	A 084		

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A 084	Continued From page 15 that Staff #E did not administer prescribed , and Junuvia but had erroneously documented that she had given the medications on the electronic medical record (EMOR). The DON stated that she was unaware that Staff #E had mistakenly documented medication as given on the MOR. The DON stated that Staff #E should have come to her with the occurrence, but Staff #E did not. In a follow-up interview on at approximately 11:34 AM the DON stated that Staff #E acknowledges her failure to contact the DON to address the documentation mistake. The DON stated that the Staff #E did not follow training procedures regarding assistance with self-administration of medications and accurate documentation and record keeping. Staff #E did not notify facility administration about the error in documentation and to correct Resident #1's medical record. Class III	A 084		
A 160	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a	A 160		

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A 160	Continued From page 16 conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177,	A 160		

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A 160	Continued From page 17 F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.;	A 160		

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A 160	Continued From page 18 (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident medical records are readily available for review. This was evidenced by the facility failure to timely provide requested medical records to emergency personnel for 1 of 1 sampled resident's (Resident #1) who was transferred to a higher level of care for evaluation of . The findings include: Review of hospital emergency room record for Resident #1 dated revealed the Assisted Living Facility (ALF) had issues providing medical information promptly to 911 personnel. The record revealed no medical history was available for review by emergency personnel and emergency room medical staff. Review of the facility policy for resident transfer documentation revealed "when sending residents to hospital the following documents MUST be given to paramedics: copy of the aesthete, copy of the insurance card, medication list, copy of Power of Attorney (POA) document, original ( ) form and copy of 1823 Resident Assessment form." In an interview with Staff #B on at 4:03 PM, she stated she was on duty on during the 3-11p shift. She stated she was clocking out from her shift and observed police and emergency personnel attending to Resident	A 160		

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A	Continued From page 19 #1 who was assessed to be unresponsive. She stated she thought "what is going on here? " and went to the nurses' station to begin assisting Staff #C with organizing and preparing copies of Resident #1's medical record for 911 personnel. Staff #B stated the 911 personnel were rushing to get the records and transport the resident for evaluation and treatment. She stated she was not sure who was given Resident #1's medical record copies. She stated she had been trained on what paperwork was required for all 911 transfers, including the resident sheet, 1823 form, medication list and form. In an interview with the Administrator on at approximately 1 PM, she stated that facility staff are in-serviced on the required documentation for any resident transfer to the hospital. She stated that she was aware of prior incidents when resident medical records were not provided timely to emergency personnel. She stated that a review of the facility's current policy on documentation access and staff refresher in-service would be appropriate. Class III	A 160		