

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Margate Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5951 Colonial Drive Margate, FL 33063	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51663 Based on observations, interviews and record reviews, the facility failed to provide assistance during dining for 1 of 2 sampled residents reviewed for activities of daily living (ADLs), (Resident # 100). The findings included: A review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, revised on January 2024 documented the following: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal and oral hygiene. Record review revealed that Resident #100 was admitted to the facility on [DATE] with diagnosis of Hemiplegia, unspecified affecting right dominant side and Anemia. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score documented that Resident #100 was severely impaired. Section GG of the MDS showed that Resident #100 needs substantial/maximal assistance during dining. A review of the Order Summary Report revealed the following: an order dated 12/21/2022 for regular diet pureed texture, honey/ moderately thick consistency, Fortified foods one time a day which was dated 04/30/2023, and an order for Enteral Feed Jevity 1.5, 250 milliliters (ml) bolus 3 times a day which was dated 07/17/2024. In an observation conducted on 11/04/2024 at 8:45 AM, Resident #100 was observed in her room attempting to eat her breakfast from the tray, without staff in the room. Resident #100 was just staring at her breakfast plate and not attempting to eat alone. About 10 minutes later, Resident #100 was observed still unattended with her breakfast tray. In an observation conducted on 11/04/2024 at 12:50 PM, Resident #100 was observed in her room looking at her lunch tray with an expression of discomfort on her face. About 20 minutes later, Resident #100 was still observed unattended and attempting to eat on her own without much success. In an observation conducted on 11/05/2024 at 8:11 AM, Resident #100 was observed in her room eating and spilling whitish food like substance from the breakfast tray that resembled cold cereal. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 105505	Facility ID: 105505 If continuation sheet Page 1 of 11

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 11/05/2024 from 12:41 PM to 12:56 PM, Resident #100 was observed in her room dressed in a hospital gown that was stained with food particles as she was attempting to eat alone. During that 15-minute period it was also noticed that most of the plate was spilled on the top part of Resident #100's gown. At 1:42 PM, the lunch tray was taken out of the room and Resident #100 was partially cleaned but not around her gown area. A thorough review of Resident #100's Care Plan dated 11/19/2024 stated the following: Observe meal intake, and report lack of intake. In an interview conducted on 11/06/2024 at 10:00 AM with Staff D, Minimum Data Set (MDS) assessment Coordinator for Long Term Care (LTC) was asked the meaning of substantial/maximal assistance during dining for Resident #100. She stated that staff would need to provide more than 50% of the work while feeding Resident #100. This would require handover hand assistance during the entire mealtime. According to Staff D, staff would be doing most of the work and be present throughout the feeding process. In an interview conducted on 11/06/2024 at 10:20 AM with Staff E, Certified Nursing Assistant (CNA), she stated Resident #100 can eat alone and doesn't need assistance. She further stated that Resident #100 usually eats between 50 to 75 % of her food. In an interview conducted on 11/06/2024 at 10:30 AM with the facility's clinical Dietitian she stated that Resident #100 has a varied intake of meals and that she is also on tube feeding regimen to substitute for the remaining intake of meals. The goal is to eventually decrease the tube feeding until most of Resident #100's intake comes from the diet by mouth. The Dietitian also reported that Resident #100 needs assistance with her meals and it is important to eat her meals since they are fortified for added nutritional value.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on observation, interviews and record review, the facility failed to provide emergency dental service for 1 of 1 sampled resident reviewed for dental services (Resident #125). The findings included: Record review revealed Resident #125 was admitted to the facility on [DATE] with diagnoses that included Aphasia following cerebral infarction, Cerebral infarction, and Type 2 diabetes mellitus. Her Brief Interview for Mental Status (BIMS) score was 1 (indicating severe cognitive impairment), on the quarterly Minimum Data Set (MDS) with a assessment reference date of 08/30/24. On 11/04/24 at 10:30 AM Resident #125 was interviewed as part of the initial screening process. She could not answer questions asked but when the surveyor asked if she had pain she nodded yes and grabbed the left side of her face. The surveyor then spoke with Staff A, a Registered Nurse (RN), relaying that the resident indicated to the surveyor that she had pain on the left side of her face. An additional interview was conducted with the resident on 11/05/24 at 1:55 PM in her room. She was asked how she was feeling today and she pointed to the left side of her face. When asked if it was the same pain as yesterday she nodded yes. When asked if it was tooth pain she nodded yes. An interview was conducted with Staff A on 11/05/24 at 2:00 PM regarding if the resident was given anything for pain yesterday. She responded that she did not remember but if she did, it would be documented in the computer. Staff A was asked if the resident had been complaining of tooth pain and Staff A stated that she did not know. A review of the documentation for 11/04/24 revealed the resident did not receive any pain relief and there was no nursing documentation relating to tooth pain. An interview was conducted Staff B, a Social Worker, on 11/05/24 at 2:15 PM. Staff B was asked if the resident had been seen by the dentist. She called the dental service that provides care to the facility. They stated she had not been seen. Staff B stated she was not on the list to be seen by the dentist. She was then asked what the procedure was after a dental consult order was put in. She stated the nurse would usually notify the Social Worker to make the appointment but maybe it slipped through the cracks because the resident went into long term recently. A review of progress notes revealed prn (as needed) medication administration of (Acetaminophen tablet 325 milligrams 2 tablets by mouth every 6 hours as needed for pain) was administered on the following days for tooth pain: 11/06/24, 11/05/24, 10/15/24 for toothache 7/10 (pain level), 10/11/24 for toothache 7/10, 10/04/24 for a toothache 7/10, 10/02/24 for a toothache 8/10, 09/13/24 for toothache 7/10, and 09/07/24 for toothache 7/10. On 09/07/24 a dental consult was ordered. The dentist saw the resident on 10/21/24. Record review revealed the facility did not reach out to the dentist when the resident continued to complain of tooth pain and the dentist had not yet come to see her. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/06/24 at 3:24 PM, the dentist called the surveyor. He stated he was unable to determine when the office received the referral from the facility to see Resident #125. He stated he did not think it was on 09/07/24 because he was in the facility after that and before 10/21/24 and she was not seen at that time. He said he did not realize the resident had tooth pain because she would have been seen earlier in that case. He stated it could have been his fault that there was a delay but he can't say for sure. He stated there had been change in social workers in the facility and problems with communication. On 11/07/24 at 9:13 AM, an interview was conducted with Staff C, a Licensed Practical Nurse, regarding what she would do if her resident had tooth pain. She stated she would ask when it started, is it new, how bad is the pain, give pain medication if the resident has an order, see if it was effective or not, and notify the doctor.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40153 Based on observations, interviews and record review, the facility failed to provide food in a form that meets the needs for the Mechanical Soft Diets, during dining observations for 6 residents out of 37 residents on a Mechanical Soft Diet (Resident #127, Resident #22, Resident #101, Resident #47, Resident #104 and Resident #24). The findings included: A review of the facility's diet guidelines (provided by the clinical dietitian) which was titled, Eating Guide for Mechanical Soft Diets dated 2022 documented the following: Recommended vegetables that are well cooked, diced such as carrots, peas, green beans, beets, butternuts, squash and wax beans. It further documented that the starches like pasta need to be diced soft pasta or noodles. 1. Record review documented that Resident #127 was readmitted to the facility on [DATE] with diagnoses of Cognitive Communication Deficit. The Significant change Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 09 which is moderate cognitive impairment. In an observation conducted on 11/04/24 at 12:54 PM in the Restorative dining room, Resident #127, was observed eating on her own. Closer observation revealed a lunch meal with the following: a Mechanical soft/easy to chew diet. The tray had pasta, chicken parmesan, garlic bread, and California vegetables (carrots, broccoli, and cauliflower). Closer observation revealed that the California vegetables were over 2 inches in length and partially cooked. This Surveyor attempted to cut through the carrots, broccoli, cauliflower, and the white pasta using a fork. A strong force was applied attempting to cut through the above food items which was difficult. 2. Record review revealed that Resident #22 was admitted on [DATE] with diagnoses of Dementia and type 2 Diabetes. the 5-day MDS assessment documented a BIMS score of 03, which is severe cognitive impairment. In an observation conducted on 11/04/24 at 1:00 PM, Resident #22 was observed eating in her room on her own. Closer observation revealed a lunch meal with the following: a Mechanical soft/easy to chew diet. The tray had pasta, chicken parmesan, garlic bread, and California vegetables (carrots, broccoli, and cauliflower). Closer observation revealed that the California vegetables were over 2 inches in length and partially cooked. This Surveyor attempted to cut through the carrots, broccoli, cauliflower, and the white pasta using a fork. A strong force was applied attempting to cut through the above food items which was difficult. In this observation, Resident #22 said that she is not eating the California vegetables on her lunch tray because it makes her sick and she is not able to cut the vegetables. 3. Record review revealed Resident #101 was admitted to the facility on [DATE] with diagnoses of Hyperlipidemia and Hypertension. The Quarterly MDS 09/17/24 documented a BIMS score of 04, which is severe cognitive impairment. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation conducted on 11/4/24 at 1:00 PM, Resident #101 was observed eating on his own. Closer observation revealed a lunch meal with the following: a Mechanical soft/easy to chew diet. The tray had pasta, chicken parmesan, garlic bread, and California vegetables (carrots, broccoli, and cauliflower). Closer observation revealed that the California vegetables were over 2 inches in length and partially cooked. This Surveyor attempted to cut through the carrots, broccoli, cauliflower, and the white pasta using a fork. A strong force was applied attempting to cut through the above food items which was difficult. 4. Record review revealed that Resident #47 was admitted to the facility on [DATE], with diagnoses of Dementia and Depression. The Quarterly MDS assessment dated [DATE] documented a BIMS score of 02, which is severe cognitive impairment. In an observation conducted on 11/6/24 at 12:15 PM, Resident #47 was noted in the room with the lunch meal. The meal ticket was noted with a Mechanical soft/easy to chew diet. The lunch plate was noted with long strands of pasta (not diced), Mechanical soft shrimps and Bermuda Vegetable blend (carrots, broccoli, peppers, and string beans) that were more than 2 inches in length and not well cooked. 5. Record review revealed Resident #104 was readmitted to the facility on [DATE] with diagnoses of Hypertension and Type 2 Diabetes. The Quarterly MDS assessment dated [DATE] has a BIMS score of 09, which is moderate cognitive impairment. In an observation conducted on 11/06/24 at 12:14 PM, Resident #104 was noted in the room with the lunch meal. The meal ticket was noted with a Mechanical soft/easy to chew diet. Closer observation showed a lunch plate with a Bermuda Vegetable blend that were more than 2 inches in length and not well cooked. 6. Record review revealed that Resident #24 was admitted to the facility on [DATE] with Chronic Respiration Failure. The significant change MDS assessment dated [DATE] documented a score of 00 for the BIMS, which was unable to be completed. In an observation conducted on 11/06/24 at 12:16 PM, Resident #24 was eating her lunch meal. Closer observation showed a meal ticket with Mechanical soft/easy to chew diet. The lunch plate was noted with long strands of pasta, Mechanical soft shrimp and Bermuda Vegetable blend (carrots, broccoli, peppers, and string beans) that were more than 2 inches in length and not well cooked. 7. In an observation conducted on 11/6/24 at 12:27, Resident #127 was noted in the dining room eating her lunch meal. The meal ticket was noted with a Mechanical soft/easy to chew diet. The meal plate was noted with long strands of pasta, Mechanical soft shrimps and Bermuda Vegetable blend (carrots, broccoli, peppers, and string beans) that were more than 2 inches in length. In this observation this Surveyor attempted to cut through the spring beans using the fork and was not able to cut through even with using strong force. 8. In an observation conducted on 11/06/24 at 12:47 PM, Resident #127 was in the dining room eating her lunch meal. Closer observation revealed Bermuda Vegetable blend (carrots, broccoli, peppers, and string beans) that were more than 2 inches in length. In this observation, Resident #127 attempted to cut through the green beans using a fork but was not able too. She then said to this Surveyor this is too hard to cut. (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview conducted on 11/07/24 at 9:09 AM with the facility's Speech Therapist, she was asked about the Mechanical soft diet/easy to chew diet. The vegetables need to be soft enough so when you put a fork into it, it should be easily cut through. She further said that it should not be difficult to cut or be tough. In an interview conducted on 11/07/24 at 9:20 AM with the facility's Dietitian she said that the vegetables on the Mechanical soft diet need to be soft and said, easy to crunch through.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, observation, interview and record review, the facility failed to 1) don appropriate personal protective equipment (PPE)/aprons while handling resident linen/gowns, during a Laundry Room Tour, 2) ensure that it donned appropriate (PPE)/gloves for a resident during a Glucometer Observation Demonstration for 1 of 2 sampled residents observed, (Resident #110,) and 3) appropriate (PPE) with a resident on Enhanced Barrier Protections (EBP) In accordance to CDC (Center for Disease Control and Prevention) guidelines and recommendations for 1 of 35 residents observed for EBP, Resident #116. The findings included: 1) Record review of the un-dated facility policy and procedure titled, Laundry provided by the Director of Nursing (DON) documented in the Policy Statement: Standard: It will be the standard of this facility to use guidance from the most current infection control guidelines provided by the Centers for Disease Control (CDC) Infection Control Policy and Procedure Manual Volume I and II, as it relates to Contaminated/Isolation Room Cleaning to assist with the prevention in the transmission of infectious agents within the healthcare setting. Guideline: A. The employee will don with the appropriate Personal Protective Equipment (PPE) per facility standard and guidelines Precautions to Prevent Transmission of Infectious Agents, prior top handling contaminated linen or clothing. 1. Contaminated/Isolation Laundry Procedures will consist of: a) Employee must wear appropriate PPE while sorting resident linens and personal clothing. b) Employee should not allow linen or resident personal items (clean or dirty) to touch their clothing or uniform . During a Laundry Room tour conducted on 11/05/24 at 10:24 AM with the Director of Maintenance/Housekeeping, two (2) of the facility ' s laundry room aides were observed folding up clean resident linens and resident gowns in a facility uniform; allowing the resident's clean gowns and linen to come into contact with their uniforms. An interview was conducted consecutively, with both of the laundry aides, Staff H and Staff I, regarding their wear and use of the facility ' s uniform in the laundry, and both laundry aides revealed that they wear the same facility uniforms, while in the process of folding up clean resident linens and resident gowns, from home to work and back home again; both aides were observed directly folding and handling clean resident linens and resident gowns, without wearing (PPE)/aprons. An interview was conducted on 11/05/24 at 10:28 AM, with the Maintenance/Housekeeping Director, and he acknowledged that the laundry aides should be wearing aprons atop their uniforms, while folding up clean resident linens and resident gowns. The facility laundry staff aides did not don an apron, while folding up clean resident linens and resident gowns, until after surveyor intervention. The Administrator further recognized and acknowledged on 11/05/24 at 10:34 AM, that appropriate PPE/aprons should always be worn in the laundry room area by facility staff, while folding up clean resident linens and resident gowns; this was not done. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Review of the facility policy and procedure on 11/04/24 at 2:36 PM titled Blood Sampling - Capillary (Finger Sticks) provided by the DON reviewed January 2024 documented in the Policy Statement: Purpose: The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees. Equipment and Supplies .4. Personal protective equipment (e.g. gloves); .General Guidelines: 1. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses .Steps in the Procedure .2. [NAME] gloves 9. Remove gloves, and discard into appropriate receptacle . Resident #110 was admitted to the facility on [DATE] with diagnoses which included Diabetes Mellitus, Dementia, Hemiplegia and Hemiparesis, Gastrostomy Tube, Atherosclerotic Heart Disease and Hypertension. She had a Brief Interview Mental Status (BIM) score indicating (severe impairment). During a Blood Sugar Level (BSL) Accucheck reading observation conducted for Resident #110 on 11/04/24 at 11:14 AM, Staff F, a Licensed Practical Nurse (LPN), was observed using the Microdot minute wipes to initially clean the Glucometer machine prior to resident use. However, Staff F, was observed, first donning a pair of gloves (PPE) to utilize during the first Glucometer machine cleaning and check. Staff F, was actually observed cleaning the Glucometer machine with her bare hands. Next, Staff F, then sanitized her hands and gathered the supplies and went to the resident, who agreed to have this surveyor observe the Accucheck being performed. Staff F, then washed her hands again for 30-45 seconds, donned a clean pair of gloves and proceeded to take Resident #110 ' s blood sugar sample from her left hand-third finger. Again, Staff F, nurse was observed using the Microdot minute wipes in order to clean the Glucometer machine between uses, and she allowed it to air dry for 2-4 minutes. However, again Staff F, was not observed, first donning a pair of gloves after completing the second Glucometer cleaning and check; for resident use. Staff F, had been observed again, cleaning the used Glucometer machine with her bare hands. Next, the nurse sanitized her hands and gathered the supplies again and went to the resident's room and she again agreed to have this surveyor observe the Accucheck being performed. The nurse then washed her hands again for 30-45 seconds, donned a clean pair of gloves, and then proceeded to re-check the resident ' s blood sugar at 11:53 AM, from the left hand ring fourth (4th) finger. Resident #110 had received an 8 oz. carton of liquid Boost Glucose Control as provided by Staff F. Staff F, then washed her hands for 30-45 seconds, applied a pair of gloves and then drew up four (4) units of Novolin R flex pen and administered it in the Resident #110's left upper arm; after she was observed first wiping the resident's skin area down with an alcohol pad prior to and after the injection. Finally, Staff F threw the used lancets into the sharp's container, removed her gloves and washed her hands for approx. 35 -40 seconds. On 08/19/23 the original and on 11/04/24 the current physician's orders documented to, check blood glucose via finger stick one time a day related to Diabetes Mellitus due to underlying condition with Hyperglycemia. An interview was conducted with Staff F a (Licensed Practical Nurse), LPN, on 11/04/24 at 2:54 PM, regarding her not wearing PPE (gloves) during the Glucometer Observation, and she acknowledged that she did not wear any PPE (gloves) during the Glucometer cleaning, and she indicated that she should have. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Staff G a (Registered Nurse), RN Unit Manager for the South Wing, on 11/04/24 at 3 PM regarding Staff F, not wearing PPE (gloves) during the Glucometer Observation and she also acknowledged that gloves should have been worn during the Glucometer Observation, for Resident #110. Record review of Resident #110 's Medication Administration Record (MAR) for November 2024 documented that Resident #110 was ordered the following two (2) injectable and two (2) oral Hypoglycemic medications: Basalar Kwikpen inject 60 units subcutaneously at bedtime related to Diabetes Mellitus due to underlying condition with Hyperglycemia, and Novolin R Flexpen insulin inject as per sliding scale related to Diabetes Mellitus due to underlying condition with Hyperglycemia. Record review of the Resident #110's original Enhanced Barrier Precaution (EBP) Care plan initiated 04/18/24 and revised 07/16/24 documented to Maintain enhanced barrier precaution as indicated during dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or Intravenous (IV) access line care, urinary catheter care, feeding tube care, tracheostomy/ventilator care, ostomy care, or during wound care. In summary, the nurse was observed cleaning the Glucometer machine for resident use, a total of four (4) separate times, with her bare hands, without first donning a pair of gloves (PPE). The DON further recognized and acknowledged that on 11/04/24 at 3:15 PM that PPE should always be worn during resident Glucometer cleaning and care; this was not done. 50370 3.) According to CDC, Enhanced Barrier Precautions included the following: Everyone must clean their hands including when both entering and leaving the room. Providers and Staff must also; wear gloves and a gown for the following: high-contact care resident care activities, dressing, bathing-showering; transferring; changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy; Wound Care any skin opening requiring a dressing. https://www.cdc.gov/long-term-care-facilities/media/pdfs/EBP-KeepResidentsSafe-Poster-508.pdf. Resident # 116 was originally admitted on [DATE] and readmitted on [DATE], with diagnoses including Unspecified dementia, Dysphagia-orpharyngeal phase (swallowing difficulty occurs when food or liquid is moved from mouth to throat), generalized muscle weakness, (DTI) Deep Tissue Injury of left bunion and Sacral wound Stage 4 pressure ulcer. Record review of physician order dated 08/05/24 with active status during this survey on 11/07/24, revealed Enhanced Barrier Precaution: Maintain Enhanced Barrier Precautions for Sacral Wound. Further review of Nursing Care plan dated 08/05/24, 08/09/24 and 08/14/24 revealed Resident #116 requires EBP (enhanced barrier precaution) related to open wound. The interventions related to EBP included: educate resident, responsible party or caregivers regarding enhanced barrier precaution, follow infection control guidelines as indicated, maintain enhanced barrier precaution as indicated during dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or IV access line care, urinary catheter care, feeding tube care, tracheostomy/ventilator care, ostomy care, or during wound care. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105505	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Margate Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5951 Colonial Drive Margate, FL 33063	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Additional record review of weekly skin check dated 11/02/24, revealed that wound care was administered to sacrum per doctor's order. Additional note revealed that a forehead scab was resolving after a fall resulting to hematoma. Further review of wound care progress notes dated 11/04/24 revealed Resident #116 remains on wound care for stage 4 wound to sacrum. The wound was noted with moderate serosanguinous drainage with no bad odor. The surrounding areas were noted to be flat and intact, with 70% pink coloration of soft healthy/adequate granulation tissue, 10% exposed ligaments, and 30% epithelized tissue. The wound was stable, with no significant changes. A review of MDS (Minimum Data Set) Section C dated 11/05/24, revealed a score of 10 indicating Resident #116 has a mild cognitive impairment. MDS' Section GG -A on eating: the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident, revealed Resident #116 requires moderate set up or clean up assistance. Section GG-I on Personal hygiene: the ability to maintain personal hygiene, including washing/drying face and hands, revealed Resident #116 requires substantial and maximal assistance. Section E0800 on Rejection of Care-Presence & Frequency: if resident reject evaluation or care (e.g. ADL assistance) that is necessary to achieve the resident's goals for health and well-being, revealed a 0-score, indicating behavior is not exhibited by Resident#116. During an observation on 11/06/24 at 09:30 AM, a CDC Enhanced Barrier Precaution sign was posted on Resident #116's door. Staff J, a [NAME] Wing Unit Manager answered the call light of Resident# 116, who was sitting on a wheelchair in front of a table containing a breakfast tray. Staff J, a Unit Manager pressed the light switch off on the wall. She proceeded to adjust the breakfast table, then repositioned Resident #116's right and left lower legs and socked feet. Closer observation revealed scattered brownish skin discoloration on the anterior portion of both lower legs. Staff J, a Unit Manager was not wearing any personal protective equipment like gloves. She told Resident #116 that she will feed her. Closer observation revealed Resident #116's spoon was buried under the pureed brown and yellow colored food. There were linens and a pillow on top of a chair, related to the Maintenance Staff removing all bed linens earlier to fix Resident #116's bed and to replace mattress. Without hand hygiene after touching Resident's lower legs, and feet, Staff J, a Unit Manager grabbed and bunched all the bed linens, including a red blanket with no gloves. She left the room without performing hand hygiene and came back with a pillowcase which she used for a pillow on top of a chair. Staff J, a Unit Manager did not perform hand hygiene when she left the room again and came back with a plastic bag, where she placed Resident #116's bed linens, and pillow using bare hands. She placed all plastic contained linens and a pillow inside Resident's locker. Resident #116 stated she was cold, so Staff J using her bare hands placed Resident #116's red blanket on top of Resident's neck, chest, arms and middle body. Staff J, a Unit Manager left the room one more time and came back holding a blue PPE (Personal Protective Equipment) gown. She donned a PPE gown but did not put on gloves. Staff J, a Unit Manager sat on a now empty chair and started to feed Resident # 116. She was not observed encouraging Resident #116 to perform any hand hygiene, nor give her hand sanitizer, or wet towel with soap before eating. Staff J did not perform any hand hygiene herself before feeding Resident #116. After she poured the contents of a boxed supplement in a container, Staff J, a Unit Manager asked Resident # 116 to hold the container. During an interview with the Administrator on 11/07/24 at 1:00 PM, the above observation was shared.		