STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105505	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Margate Health and Rehabilitation Center	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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide the correct dosage of medication for 1 of 6 sampled residents, reviewed for medication administration (Resident #49). The findings included:Record review revealed Resident #49 was admitted to the facility on [DATE] with diagnoses that included: Cerebral Palsy, Peripheral Vascular Disease, and Seizures. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], documented his Brief Interview for Mental Status (BIMS) score was 14, which indicated he had intact cognition. On 04/07/26 at 10:45 AM during the medication administration observation, Staff B, a Licensed Practical Nurse (LPN), prepared the following medications to be given to Resident # 49: Primidone 50 MG (milligrams) Oral Tablet 1 tab daily; Metformin 500 mg 1 tab twice a day; Baclofen 10 MG Oral Tablet 1 tab twice a day; Lidocaine 0.04 MG/MG Medicated Patch 1 patch topically every 12 hours; and Levetiracetam 750 MG Oral Tablet 1 tab (a medication used to help control certain types of seizures). During the observation, Staff B administered the medications, and the surveyor asked her to review the order for Levetiracetam again. She looked at it and realized the order was for Levetiracetam 750 MG Oral Tablet 2 tabs twice a day. She then prepared another tab of Levetiracetam and administered the medication to Resident #49. This was discussed with the Director of Nursing (DON) immediately after the observation. She acknowledged understanding and said the resident should have initially been given 2 tabs of Levetiracetam.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide the medications as per physicians' orders for 1 of 2 sampled residents reviewed for dialysis (Resident #13). The findings included:Record review revealed Resident #13 was readmitted to the facility on [DATE] with diagnoses of dependence on renal dialysis, anemia, and type 2 diabetes. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #13 had a Brief Interview of Mental Status (BIMS) score of 15, indicating cognitive intactness. A review of the physician's orders revealed the following orders: Velphoro Oral Tablet Chewable 500 milligrams (phosphate binder), give 1 tablet by mouth with meals for chronic kidney disease dated 02/15/26. Hydroxyzine HCl oral tablet 25 milligrams gives 1 tablet by mouth four times a day for anxiety, dated 10/31/26. Prednisolone Acetate ophthalmic Suspension 1 %, instill 1 drop in both eyes every 6 hours for inflammation of the eye dated 02/01/26 Hemodialysis outpatient every Monday, Wednesday, and Friday, with pickup at 9:00 AM and dialysis chair time at 10:00 AM, dated 02/15/26. In an interview conducted on 04/06/26 at 4:35 PM, it was revealed that Resident #13 had just returned from her dialysis treatment. She stated that she is aware of the importance of taking her phosphate binders, and the dialysis unit notified the facility to ensure that the binders' medications are given with meals. She further reported leaving the facility around 8:30 AM and coming back around 3:30-4:00 PM on her dialysis treatment days. According to Resident #13, her binders are often not given with her meals. In an observation conducted on 04/07/26 at 8:26 AM, Resident #13 was noted in her room with the breakfast tray. When asked whether her binder medication was given with breakfast, she said, Not yet. A review of the Medication Administrator Record (MAR) dated 04/07/26 documented that the binder medication was given at 7:30 AM. In an interview conducted on 04/07/26 at 11:48 AM with Staff A, a Licensed Practical Nurse, she stated that she recently went to administer two binder medications to Resident #13, and the resident said to wait until lunch. When asked by this Surveyor why she documented the binder as given at 7:30 AM, Staff A reported it was a mistake and that she would go back and change her documentation. In an interview conducted on 04/07/26 at 1:20 PM with Resident #13, she stated that Staff A gave her the two binder medications 'not too long ago', the one she missed this morning and the lunch dosage. In an interview conducted on 04/07/26 at 1:30 PM with Staff A, she stated she should not have marked the medication Velphoro as given this morning. According to her, Resident #13 did not receive her breakfast tray this morning, so she did not give her the medication. Staff A further reported that she gave Resident #13 two binder medications during her lunch meal to compensate for the missing dosage this morning. Continued review of the MAR revealed documentation that Hydroxyzine was administered on 04/03/26 at 3:03 PM and on 04/06/26 at 1:39 PM. The medication Prednisolone was given on 04/03/26 at 11:41 AM and on 04/06/26 at 11:03 AM. These medications are scheduled to be given at a time when the resident is supposed to be at dialysis. In an interview conducted on 04/07/26 at 3:42 PM, the Director of Nursing stated that they will try to adjust the medication schedule to accommodate Resident' #13's dialysis days and times. She would consult with the provider to adjust the medication's schedule. In this interview, she was notified of inconsistencies in the medications given, as reviewed on the MAR.