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
	AL11964403	A. BUILDING: _____ B. WING _____	R 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARGO III	3669 SW 24 TERRACE MIAMI, FL 33145

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A revisit survey was conducted at Villa Margo III Inc on to . Deficiencies were identified at the time of the survey. Class I deficiencies were found at tags A0010 and A0030. A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The facility failed to determine the appropriateness of continued residency for Resident # 1 who was unable to transfer to a wheelchair without total physical assistance from Staff; and hit his against the wall while sitting in his wheelchair without personal assistance or . (A0010) and failed to ensure the residents received access to adequate and appropriate healthcare. Resident # 1 was hospitalized and required follow-up care that he did not receive. (A0030). The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 10:55 AM. The census at the start of the survey was 11 residents. The following is a description of the deficiencies found at the time of the visit.	{A 000}		

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A 010 SS=J	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for	A 010		

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A 010	Continued From page 2 nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.	A 010		

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A 010	Continued From page 3 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions	A 010		

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A 010	Continued From page 4 are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview, and records review the facility failed to determine the appropriateness of the continued residency for one out of 10 sampled Resident (#3). Resident # 3 could not transfer to a wheelchair without total	A 010		

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A 010	Continued From page 5 physical assistance or sit safely in a wheelchair without personal assistance or physical . When left unattended in his wheelchair without assistance or a , Resident # 1 hit his and suffered a large hematoma on his right hematoma on orbit. Findings included: Observations on at 6:30 AM showed Resident # 3 was on an adjustable bed with a full bed rail. Further observations showed that Resident # 3's right was , and he could not extend the . Resident # 3 was also wearing briefs. During an interview on at 6:35 AM Staff G stated that Resident # 3 cannot get out of bed by himself and needs two staff to help him. Staff G stated that Resident # 3's full was on them when staff had to lift the resident from the bed to his wheelchair. A review of Resident # 3's health assessment dated showed that Resident # 3 was diagnosed with prostatic hyperplasia, , and . Physical limitation included assistance with devices (wheelchair), universal precautions. Resident # 3 needed assistance with ambulation, supervision with bathing and was independent with transferring, toileting, grooming, eating, . Resident # 3 needed assistance with the self- administration of medications. Observation on at 8:00 AM showed Staff G and H were getting Resident # 3 out of bed to take his medications and eat breakfast.	A 010		

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A 010	Continued From page 6 Staff G and H both lifted Resident # 3 out of bed and onto his wheelchair, and Resident # 3 were and not supportive during the transfer. Additionally, a large hematoma and were observed on Resident # 3's right orbit. During an interview on at 8:41 AM Staff H stated that Resident # 3 struck his when he was unattended in his wheelchair on at 11:20 AM. When asked if Resident # 3 was able to transfer from the bed to the wheelchair on his own, Staff H said "no." Staff H further stated that Resident # 3 full body was supported by them when he was transferred. When asked about bathing and toileting she stated that he could not do these by himself. Staff H stated that Resident # 3 had never been able to transfer independently since she had started working at the facility on . During an interview on at 8:50 AM Staff G stated that Resident # 3 had not been able to transfer independently since she started working at the facility on . She stated that there were days that he was stronger than others. A review of the facility hospital log showed that Resident # 3 was hospitalized on 3 occasions. The resident was sent to the hospital on for and functional decline; on for debilitation; and on for . A review of Resident # 3 records showed that he was not under hospice care but was receiving home health care for to his left and left and right ordered by Resident # 3 podiatrist on .	A 010		

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A 010	Continued From page 7 During an interview on at 9:15 AM the Administrator stated that Resident # 3 was not reassessed after his hospitalizations. When asked if he believed that resident conditions had changed in the last two months, he did not answer. When asked if his staff were able to assist the resident without carrying the resident full , he stated that the other staff had no problem lifting him because she was stronger. A review of the facility's admission, retention and discharge policy showed that "resident ... must quality as an eligible resident under Florida Statutes, Ch. 429." and also showed that "the administrative rules ... prevent resident to continue to reside in the facility if they require more than supervision of or assistance with ambulation, grooming, bathing, eating, and ." Class I	A 010		
A 030 SS=K	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident	A 030		

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A 030	Continued From page 8 complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical . (e) Residents may not be required to perform any	A 030		

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A 030	Continued From page 9 work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including	A 030		

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A 030	Continued From page 10 receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and	A 030		

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A 030	Continued From page 11 recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The	A 030		

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A 030	Continued From page 12 notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for	A 030		

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A 030	Continued From page 13 the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and review records, the facility failed to ensure that one out of 10 sampled resident (# 3) received assistance with obtaining access to adequate and appropriate healthcare. Resident # 3 had a , was hospitalized on several occasions and did not receive appropriate health care. The facility also failed to ensure that two out of 10 sampled residents (#8 and #10) were treated with consideration and respect and had no access to a phone and the hotline. Residents # 8 and #10 were bathed in another resident's room while staff used their bathroom, the facility did not have a working phone for residents to use, and the staff did not knock before entering residents' rooms. Findings included: 1) Observation on at 8:00 AM showed Staff G and H were getting Resident # 3 out of bed to take his medications and eat breakfast. Resident # 3 was observed with a large hematoma and on his right orbit. During an interview on at 8:03 AM Staff G mentioned that Resident # 3 struck his on against the wall. A review of Resident # 3's health assessment dated showed that Resident # 3 was	A 030		

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VILLA MARGO III	3669 SW 24 TERRACE MIAMI, FL 33145

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A 030	Continued From page 14 diagnosed with prostatic hyperplasia, , and . Physical limitation included assistance with devices (wheelchair), universal precautions. Resident # 3 needed assistance with ambulation, supervision with bathing and was independent with transferring, toileting, grooming, eating, . Resident # 3 needed assistance with the self-administration of medications. During an interview on at 8:41 AM Staff H stated that Resident # 3 struck his when he was unattended in his wheelchair at 11:20 AM on . Staff H stated that they called the Administrator after the incident but did not send the resident to the hospital. During an interview on at 8:50 AM the Administrator stated that that he called the home health nurse who was treating the resident for to his extremities after the incident. The Administrator stated that he did not contact the resident primary care doctor after the incident. During an interview on at 8:56 AM The home health nurse stated that the injuries that the resident sustained were not serious and were superficial. When asked if he had communicated with the primary care doctor the nurse stated that he was a doctor a Cuba. During an interview on at 9:10 AM the Administrator stated that he should have sent the resident to the hospital yesterday. A review of Resident # 3 progress notes showed that there were no documented progress notes documenting any call the Resident # 3's primary	A 030		

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A 030	Continued From page 15 care physician. A review of the facility hospital log showed that Resident # 3 was hospitalized on three occasions. The resident was sent to the hospital on for and functional decline; on for debilitation; and on for . A review of the hospital records from showed that Resident # 3 was unable to ambulate due to rigidity and stiffness. His medications were adjusted; he was discharged on ; and he was recommended to follow up in a week with a and his primary care doctor in a week. A review of the facility's "policy and procedure manual for changes in condition or status" stated that the "administrator/staff shall be responsible for notifying the resident attending physician when the resident was involved in any incident, there was a significant change in the residents' status, or when deemed necessary or appropriate in the best of the resident." A review of the facility's "policy and procedure manual for accidents and incidents" stated that "regardless of how minor an accident or incident may be ...render immediate assistance and call 911 or ask someone else to." During an interview on at 9:15 AM the Administrator stated that Resident # 3 had not received follow-up care because it had been less than a week since he returned and the doctor would come to the facility once per month. When asked about why Resident # 3 was not reassessed after the prior hospitalizations, and why he did not receive follow-up care on those	A 030		

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A 030	Continued From page 16 other occasions, the Administrator did not answer. When asked if he believed that resident conditions had changed in the last two months, he did not answer. 2) Observation on at 6:15 AM showed that Staff G was coming out of # with Resident # 8. Staff G moved Resident # 8 to # and sat her on one of the beds. During an interview on at 6:20 AM Staff G stated that Resident # 8 and #10 resided in # . She further stated that Resident # 10 was . Staff G further stated that staff would use the bathroom in Resident # 8 and # 10's room. When asked where Residents # 8 and #10 would take baths, she stated that they would receive their bath in # . Observation on at 6:20 AM showed that Staff G did not knock before entering resident rooms. Further observation showed that Residents #2 and #4 were sleeping in # . Resident # 2 and # 4's room had a bathroom. During an interview on at 6:22 AM Staff G stated that she would take residents a bath in Resident # 2 and # 4's room because it was easier for her. Observation on at 7:20 AM showed that in the living room there was a portable phone charger but no phone. Further observation showed that there was no hotline number posted in a common area. During an interview on at 7:20 AM Staff H stated that the phone was not charged	A 030		

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A 030	Continued From page 17 and that they had to hide it because one of the residents was always calling 911. Class I	A 030		
A 031 SS=D	59A-36.007(6) FAC Resident Care - Third Party Services (6) THIRD PARTY SERVICES. (a) Nothing in this rule chapter is intended to prohibit a resident or the resident's representative from independently arranging, , and paying for services provided by a third party of the resident's choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for admission and continued residency and the resident complies with the facility's policy relating to the delivery of services in the facility by third parties. The facility's policies must require the third party to coordinate with the facility regarding the resident's condition and the services being provided. (b) When residents require or arrange for services from a third party provider, the facility administrator or designee must allow for the receipt of those services, provided that the resident meets the criteria for admission and continued residency. The facility, when requested by residents or representatives, must coordinate with the provider to facilitate the receipt of care and services provided to meet the , resident's needs. (c) The administrator or designee must ensure that: 1. Care coordination includes documented communications about the resident's condition and response to treatment or services ordered by	A 031		

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A 031	Continued From page 18 the physician which may impact the resident's appropriateness for continued residency in the facility; 2. Communications occur at least once every 30 days and whenever there is a significant change in the resident's condition; and 3. If physician ordered treatments or services occur less often than once a month, communications must be conducted according to the ordered treatment or service schedule and whenever there is a significant change in the resident's condition. 4. When communication with the third party provider is unsuccessful, at least two attempts at communication on two separate days must be documented. Documentation must include the name of the person from the third party provider with whom contact was attempted, the method of communication, and the date and time of the attempts. This documentation must be included in the resident's record in accordance with the timeframes in subparagraphs 59A-36.007(6)(c)2. and 3. (d) If residents accept assistance from the facility in arranging and coordinating third party services, the facility's assistance does not represent a guarantee that third party services will be received. If the facility's efforts to make arrangements for third party services are unsuccessful or declined by residents, the facility must include documentation in the residents' record explaining why its efforts were unsuccessful. This documentation will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, interview, and records review, the facility failed to document communication about the resident condition and response to treatment for one out of 10 sampled	A 031		

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A 031	Continued From page 19 Resident (# 3). Resident # 3 was receiving care and there was no plan of care at the facility. Findings Included: Observations on at 6:30 AM showed Resident # 3's right was , and he could not extend it. During an interview on at 6:35 AM Staff G stated that Resident # 3 was receiving care from the nurse for on the . During an interview on at 8:00 AM the Administrator stated that he would need to call the nurse for documentation of Resident # 3's . The Administrator stated that the nurse knows more about the status of the . Observation on at 8:20 AM the home health nurse arrived with the plan of care and stated that the facility did not have a copy because the certification period was still open. A review of the physician's orders dated showed that the resident had a right second dorsum, a left first , , and a left first and second dorsum . A review of the nursing records for Resident # 3 showed no progress notes as to the status of the . Class III	A 031		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical	A 033		

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A 033	Continued From page 20 must have a written care plan for the use of the physical . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of , , or decline in mobility or function related to the use of the prescribed . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the appropriateness of the continued use of physical for one out of 10 sampled Resident (#3). Resident # 3 had full bed rails and there was no physician order, written plan of care, or consent for the use of . Findings Included: Observations on at 6:30 AM showed Resident # 3 in an adjustable bed with two half bed rails on the top and on the bottom of the bed. Further observations showed that Resident # 3's	A 033		

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A 033	Continued From page 21 right ◡ was , and he could not extend it. Resident # 3 was also wearing briefs. During an interview on at 6:35 AM Staff G stated that Resident # 3 cannot get out of bed by himself and needs two staff to help him. A review of Resident # 3's health assessment dated showed that Resident # 3 was diagnosed with ◡ prostatic hyperplasia, , ◡ , , ◡ , , ,

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A 079	Continued From page 22 (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.	A 079		

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A 079	Continued From page 23 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted.	A 079		

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A 079	Continued From page 24 (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time	A 079		

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A 079	Continued From page 25 specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and records review the facility failed to ensure adequate staffing standards. The facility's staff schedule did not reflect a 24-hour staffing pattern. There was only one staff was at the facility with 11 residents that require life-saving interventions and one of the residents had sustained a injury. Findings included: Observation on at 6:00 AM showed that there were no staff available to answer the door or phone. Resident # 5 had to look for Staff G who was bathing Resident # 8.	A 079		

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A 079	Continued From page 26 Observation on at 6:15 AM Staff G opened the front door and left Resident # 8 unattended after she was bathed. During an interview on at 6:17 AM Staff G stated that there was another employee scheduled to work but she believed that she had stepped out of the facility to go and run an errand. A review of the facility's staffing schedule showed that Staff G on /20206 Staff G was scheduled from 7:00AM to 7:00PM; Staff H was scheduled from 7:00AM to 7:00PM; and the Administrator was scheduled from 8:00 AM to 5:00 PM. On Staff G was scheduled from 7:00AM to 7:00PM; Staff H was scheduled from 7:00AM to 7:00PM; and the Administrator was scheduled from 8:00 AM to 5:00 PM. There were no staff scheduled from 7:00 PM to 7:00 AM. (photographic evidence obtained). Observation on at 6:18 AM showed that Staff G called someone on the phone. Staff G took Resident # 8 to her room and told her to sit in bed and wait for her. During an interview on at 6:19 AM Staff G stated that the residents did not have . Staff G stated that she was trained in , ( ). When asked if she had found an unresponsive person during her shift when she was alone, Staff G stated that she would call 911 in an emergency and wait for instructions from the dispatcher. Staff G further stated that if she did not receive instructions from the dispatcher that she would give 30 , repeatedly until 911 arrived. When asked how she would move a resident from bed to a flat surface, Staff	A 079		

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A 079	Continued From page 27 G stated that "Esa es una buena pregunta, me estas poniendo nerviosa" [interpretation: that's a good question, you're making me nervous] When asked who would open the door for 911, the staff did not answer and shook her . During an interview on at 6:22 AM Staff G stated that Resident # 3 could not get out of bed without two people providing total assistance to him. Observation on at 6:30 AM Staff H arrived at the facility. Observation on at 8:00 AM Staff G and H were getting Resident # 3 out of bed to take his medications and eat breakfast. A large hematoma was on Resident # 3 . During an interview on at 8:03 AM Staff G mentioned that Resident # 3 struck his yesterday. During an interview on at 8:41 AM Staff H stated that Resident # 3 struck his when he was unattended in his wheelchair. A review of Resident # 3's health assessment dated showed that Resident # 3 was diagnosed with prostatic hyperplasia, , and . Physical limitation included assistance with devices (wheelchair), universal precautions. Resident # 3 needed assistance with ambulation, supervision with bathing and was independent with transferring, toileting, grooming, eating, . Resident # 3 needed assistance with the self- administration of medications.	A 079		

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	AL11964403	A. BUILDING: _____ B. WING _____	R 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARGO III	3669 SW 24 TERRACE MIAMI, FL 33145

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 28 During an interview on at 9:00 AM the Administrator stated that staff were allowed to sleep, when asked why there was nobody available to open the door. Class II	A 079		
A 152 SS=E	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the	A 152		

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 152	Continued From page 29 event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility, the facility failed to provide a safe and hazard free living environment for nine out of 10 sampled residents. Findings included: Observation on at 6:24 AM showed that on the outside terrace on top of the vending machine there was a large roll of fiberglass building insulation. (photographic evidence obtained). There was also a large 2x4 wooden beam and sheet rock behind the vending machine. Further observations showed that one of the residents was smoking on the outside terrace. During an interview on at 6:24 AM Staff G stated that they don't store any fuel in the outside terrace because the residents smoke out there and propane gas was combustible. Observation on at 6:48 AM showed that a . propane tank was being stored in the Administrator office. During an interview on at 7:20 AM the Administrator stated that he kept the propane tank inside to test the generator and because	A 152		

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 152	Continued From page 30 residents would smoke outside in the terrace. According to Florida Department of Agriculture and Consumer Services, storing propane indoors was strictly prohibited. A review of the admission and discharge log showed that all the residents were designated mental health residents. Class III	A 152		