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
	AL11969092	A. BUILDING: _____ B. WING _____	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MERIDIAN AT WATERWAYS	3001 E OAKLAND PARK BLVD FORT LAUDERDALE, FL 33306

(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 An unannounced Complaint (#2022008117, #2022018163 and #2023001196) survey was conducted at The Meridian at Waterways on [redacted] through [redacted]. The facility had deficiencies identified related to Complaint #2022018163 and #2023001196 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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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,	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 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, interviews, and record review, the facility failed to ensure that adequate supervision was provided to 1 of 5 sampled residents to prevent incidence of a with injuries to Resident #5. The finding included: On at 1:15 PM, Resident #5's Private Duty Aide (PDA) was observed in the dining room of the Memory Care Unit (MCU). At first, he stood at the entrance door of the dining room while	A 025		

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A 025	Continued From page 2 waiting for Resident #5's lunch. Since the meal was not ready, the PDA decided to sit down in the dining room to wait for it. Meanwhile, Resident #5 was left alone in his room. An interview with the food Server on at about 1:17 PM, revealed he did not have sufficient food for the 19 residents present in the dining room, nor for the residents who stayed in their rooms. Therefore, the Server said that he had to leave the dining room to go to the main kitchen located on the eighth floor to request for additional food. During that time, the PDA remained in the dining waiting for Resident #5's meal. On at 1:25 PM, a tour was conducted with the Memory Care (MC) Director to the other residents' rooms of residents not observed in the dining room. During the tour, Resident #5 was found lying on the floor on his left side. Resident #5 was not able to sit up by himself, he tried but he could not. There was on the floor coming from the left of the resident. The MC Director radioed for help and thereafter left to get more assistance. Soon after, the PDA arrived and tried to assist the resident up, but he could not do so alone. Later, the MC nurse (Staff A), a Licensed Practical Nurse (LPN) arrived and assessed Resident #5's injuries. Decidedly, Resident #5 was sent to the emergency room via ambulance for a higher level of care. Review of Resident #5's Resident Health Assessment (AHCA form 1823) dated and updated on , documented that Resident #5 diagnoses were: Acute Failure, and 's . Section A of the form revealed that Resident #5 required supervision for all activities of daily living	A 025		

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A 025	Continued From page 3 (ADLs) including (ambulation, bathing, ... ,, eating, self-care, toileting, and transferring). The most recent 1823 form dated . . . . . showed that Resident #5 required assistance with all ADLs. The Food Service Director on . . . . . at 1:59 PM, reported that he has been working at this facility for three weeks. He said that he had sent enough food down to the MCU for all the residents. However, he stated that the Servers knew that they are required to deliver foods to the residents in their rooms first, before serving those in the dining room. The Wellness Director (WD) reported on . . . . . at 10:49 AM, that she has been working at this facility for five months or since . . . . . She said that the wellness of the Residents are their primary responsibility. She said that when a resident is not able to go to the dining room for dining services, the Care Staff is supposed to take their food to them. She stated that every Caretaker in the MCU is aware of this process. She said ' it is not a written policy, but a well-defined process that all Caretakers are aware of.' The WD added that Resident #5 had documented behavior problems. Resident #5 could be combative at times, she ensued. Resident #5 was frequently seen by a Psychiatrist for medication adjustment. The WD continued and stated that Resident #5 usually ate in the dining room in the morning. However, for lunch, he might either eat in the dining room or in his room depending on his daily . . . . accompanied by his PDA. In conclusion, the WD said that when Resident #5 does not go to the dining room, staff would usually bring his lunch to him in his room. The	A 025		

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A 025	Continued From page 4 WD said that Resident #5 had a history of falling. She believed that Resident #5 might have had one since she started working at this facility and others prior to her working at this facility. She said because of the Resident's behavior, the family thought that a PDA would be necessary. The PDA works 12 hours daily. On at 2:17 PM, Resident #5's PDA stated that he has been working with Resident #5 for 2 ½ years. He works from 10:00 AM to 6:00 PM daily. The PDA was observed on the balcony of the third-floor supervising Resident #5. He said that Resident #5 was doing well today. He had no broken bones from his recent . The PDA continued and said that he has been coming to this facility for two and half years, he usually takes Resident #5 to the dining room for his meals, but when he cannot go to the dining room, "I always had to go to the dining room to get his food". He said: " I was never told not to come in the dining room to take Resident #5's meal". He remarked that they posted a new directive in the dining room after Resident #5's . He said that they now put a sign to inform him that staff will bring the Resident's meal to their rooms. In the past, they would rarely deliver the food to him, when they do it, it would usually take 35 minutes after lunch. He said that no one ever stopped him from coming to the dining room before. During the exit meeting, the findings were discussed with the Administrator and the WD. They provided no additional information. Class III	A 025		
A 030	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures	A 030		

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A 030	Continued From page 5 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 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;	A 030		

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A 030	Continued From page 6 2. [illegible] and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident [illegible], neglect, and [illegible]; 6. Administrative and housekeeping schedules and requirements; 7. [illegible] 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 [illegible]. (e) Residents may not be required to perform any 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	A 030		

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A 030	Continued From page 7 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 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	A 030		

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A 030	Continued From page 8	A 030		

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 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

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A 030	Continued From page 9 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 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	A 030		

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A 030	Continued From page 10 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 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 record review, observation and interview, the facility failed to ensure a resident who had an unwitnessed . resulting in a . . . injury was provided with medical services in a timely manner for 1 of 2 residents reviewed for , Resident #1, as evidenced by Resident #1 was subsequently diagnosed with a . . . . hematoma at the hospital which potentially contributed to his . . . . ; and the facility failed to timely resolve grievances for 1 of 5 sampled residents, Resident #3, by ensuring that the plumbing system and the water temperature in Resident #3's bathroom were effectively working. The findings included: 1) Review of the Resident #1's Resident Health Assessment (AHCA form 1823) dated	A 030		

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[redacted], revealed he was admitted to the facility on [redacted] with the following diagnoses: [redacted]; [redacted] with behavioral disturbances, [redacted], and [redacted] Retention. Section 1 of the form revealed Resident #1 was [redacted] and forgetful. He required assistance for bathing and [redacted]. He ate independently, but required supervision for ambulation, self-care grooming, toileting, and transferring. It was documented he was at risk for [redacted]. Review of the resident's medication list documented he was on [redacted] which increases the potential for [redacted] if an injury should occur. Review of the Power of Attorney (POA) documents confirmed that Resident #1's spouse was his healthcare POA and two other individuals were listed as alternate POAs.

Review of a Nursing Progress Note dated [redacted] at 7:33 AM signed by Licensed Practical Nurse (LPN) Staff A documented in part, 'Report given by [redacted] that resident had unwitnessed [redacted] around 6:00 AM. Resident awake alert and verbally responsive. During the assessment resident noted with a small redness to [redacted] of [redacted] on the right side no [redacted] or any drainage noted. [redacted] to right backside right [redacted] and left side of bottom [redacted]. Resident unable to explain due to [redacted] status. Spoke with spouse to discuss findings and sending resident out to ER (Emergency Room) for further evaluation spouse refused for resident to be sent out and stated that the reddened area on resident's [redacted] was [redacted]. Left message at doctor's office awaiting call [redacted].'
Further review of the Nursing Progress Note signed by LPN Staff A dated [redacted] at 2:53 PM documented in part, 'Received a call

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from private nurse manager (name), was able to convince spouse to send resident to ER for an evaluation from unwitnessed - resident left facility around 2:20 PM via (name of ambulance service).'

There was no evidence provided to reflect the resident's physician calling and being informed of the situation, or to have the resident transferred to the hospital post with injury in a timelier manner.

In an interview conducted with the Wellness Director (WD) on at 10:29 AM, she informed that if someone , the care staff is supposed to call the nurse for an assessment to be conducted. If the was unwitnessed, the nurse should perform a range of motion assessment, paying attention to any residents' grimacing or difficulty moving , especially if they cannot tell whether they break any part of their body. Then, they obtain statements from anyone who found the resident on the floor. After the resident is assessed, the resident is sent out for higher level of care, then we notify the physician and the family. After the resident is sent out, we notify the Executive Director. If an Adverse Incident occurred, we notify AHCA (Agency for Health Care Administration). The WD said that the wellness of the residents are their primary responsibility. She further stated they called the hospital on and found out that Resident #1 was in ( ) for a diagnosis of a hematoma.

On at 1:01 PM, LPN Staff A reported that she received report from the outgoing nurse on around 7:15 AM. She was made aware that Resident #1 was found on the floor at about 6:00 AM. They had contacted the

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	AL11969092	A. BUILDING: _____ B. WING _____	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MERIDIAN AT WATERWAYS	3001 E OAKLAND PARK BLVD FORT LAUDERDALE, FL 33306

(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 030	Continued From page 13 responsible family member who instructed not to send the resident to the hospital. LPN Staff A ensued and stated that the POA argued with her and adamantly instructed her to not send the resident out to the hospital. LPN Staff A said that she then contacted the resident's Case Manager (CM) to have the POA rethink her decision. The CM called the resident's POA and told the POA to allow the facility to do their job. However, she reported that she had noticed that there was a tiny bloody and lumpy area in the of the resident's which the resident's spouse had described as . She told the spouse even though it may be , she needed to send the resident out for higher level of care because they did not witness his . Also, the resident's Private Duty Aide (PDA) had reported that she heard when the resident while she was in the bathroom. LPN Staff A stated the resident had 24-hour PDA care because the resident was combative and would, at times, try to get out of his wheelchair. She further stated the facility received a call from the spouse in the afternoon letting them know that it was okay to send the resident out. Of note, the resident was eventually transferred out to the hospital on around 2:20 PM, approximately 8 hours after his unwitnessed sustaining a injury. Review of documentation from the Department of Children and Family Services (DCF) revealed they visited the facility on . Further review revealed Resident #1 expired in the hospital on . Per the documentation, the cause of was due to complications of a closed injury; the resident at the facility and was not taken to the hospital immediately. On at 4:02 PM, during a follow up	A 030		

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A 030	Continued From page 14 interview conducted with the WD, she reported Resident #1 was found on the floor in his room the morning of . . . . . The resident was ambulating without assistance in his room and in the facility, after his . . . Resident #1 went to the dining room, ate breakfast at about 8:00 AM to 8:30 AM. The WD added that she did not deem it necessary to send the resident to the hospital at that time. However, when she observed a small red patch on the of the resident's , she became concerned and asked the nurse LPN Staff A whether she had notified the family about the red area observed. The WD said, LPN Staff A called the family again and informed the POA about the small red area, but the POA said not to send the resident to the hospital. During a further interview conducted with the Administrator on . . . . . at 4:12 PM, she informed that they have conducted extensive in-services with all care staff about the actions to take when a resident . She said because of Resident #1's . . . , they have implemented a new policy to send all residents to the hospital, if their . . were unwitnessed. Of note, the measures implemented by the facility were implemented after the visit from the DCF representative on . . 2) On , Resident #3's Representative informed and expressed that the water temperature in the resident's bathroom was not working properly which was brought to the attention of the Administrator on this date. The Representative complained that the issue was reported to the Administrator on multiple occasions and the issues were still not resolved. The Representative informed that the water was not hot and the water faucet was seemingly clogged up. It did not produce a good stream of	A 030		

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A 030	Continued From page 15 water. During a tour of the facility conducted on at 11:47 AM, it was observed that the reported concerns in Resident #3's bathroom were not yet addressed. The water pressure in the faucet was low and the water temperature was not warm to touch. It took 6 minutes for the water to reach 95 degrees Fahrenheit and then it lowered to 94 degrees Fahrenheit. Additionally, it was discovered that the water pressure, in the faucets of the bathrooms of A, were also too low. The water flow was considerably reduced. Review of the Grievance log for the month of showed that Resident #3's Representative's verbally reported concerns were not logged in or recorded. Also, there was no evidence that the issues identified in the bathrooms of were logged in. On at 12:16 PM, the Maintenance Director informed that he has been working at the facility since . He reported that he checks water temperatures every morning. He said that no one complained to him about the water temperature or the water pressure of . He added that he checked the water temperature in the common areas but not in the residents' rooms. He said that he would promptly address the concerns identified. The Administrator confirmed on at 3:53 PM, that she had received a complaint about the water temperature and pressure from Resident #3's Representative. However, she stated she did not document it in the Grievance Log. She stated that she thought she had reported the issues to the Maintenance Director,	A 030		

Agency for Health Care Administration

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A 030	Continued From page 16 but she might have forgotten. Class III	A 030		