

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910382	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/29/2025
NAME OF PROVIDER OR SUPPLIER THE MERIDIAN AT LANTANA			STREET ADDRESS, CITY, STATE, ZIP CODE 3061 DONNELLY DRIVE LANTANA, FL 33462		
(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 Relicensure, Complaint (#2024013082) and a Generator Monitoring survey was conducted on _____ at The Meridian at Lantana. The facility had deficiencies identified related to the Relicensure survey at the time of the visit.	A 000			
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable _____. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of _____ testing materials satisfies the annual examination requirement. An individual with a positive _____ test must submit a health care provider's statement that the individual does not constitute a risk of _____. 2. If any staff member has, or is suspected of having, a communicable _____, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable _____.	A 078			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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A 078	Continued From page 1 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _____ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff _____ by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of an annual freedom from _____ () statement on file for 3 out of 3 sampled staff (Staff H, Staff I, Staff O).	A 078			

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A 078	Continued From page 2 The findings included: A review of Staff H's (MedTech/Personal Care Assistant) file revealed, Staff H's hire date was . Further review revealed Staff M's annual freedom from . statement was not completed since . There was no documentation from the year 2024 through 2025. A review of Staff I's (MedTech/Personal Care Assistant) file revealed, Staff I did a hire date of . Further review revealed Staff L's annual freedom from . statement was not completed since . There was no documentation from the year 2024 through 2025. A review of Staff O's (Personal Care Assistant) file revealed, Staff O's hire date was / Further review revealed Staff O's annual freedom from . statement was not completed since . There was no documentation from the year 2024 through 2025. During an interview with Staff D (Business Office Manager, Corporate) on at 6:57 PM she was informed that the employee files were missing the annual freedom from annual statements. Staff D stated she was not aware that they were missing but she would try to locate them. Staff D acknowledged that all staff files needed to be audited to ensure compliance. She stated going forward, she would be training the onsite Business Office Manager to maintain the freedom from statements annually in the staff files . Class III	A 078		

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A 081	Continued From page 3	A 081			
A 081	429.52(1 & 7) FS; 59A-36.011() FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.	A 081			

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A 081	Continued From page 4 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its _____ control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____, may be used to meet this	A 081	

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A 081	Continued From page 5 requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies	A 081			

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A 081	Continued From page 6 and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of a mandatory 2-hour pre-service training for 1 out of 3 sampled care staff (Staff I). Additionally, the facility failed to maintain documentation and meet the requirements for the mandatory 1-hour in-service training related to Activities of Daily Living for 1 out of 3 sampled staff (Staff I) and 2-hr medication technician training updates for 2 out of 3 sampled staff (Staff H and Staff I). The findings included: During an interview with Staff D (Business Office Manager, Corporate) at 12:35 PM, a request was made for all care staff members files. Documentation was provided. A review of Staff I's (MedTech/Personal Care Assistant) file revealed, Staff I did a hire date of . Further review revealed Staff I had no documentation of a 2-hr pre-service orientation in the file. Additionally, it was revealed the staff did not have documentation of a completed Activities of Daily Living(ADL) in file. Further review of the file revealed Staff I did not have any documentation on file of the annual 2-hr continuing education for her medication	A 081			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE MERIDIAN AT LANTANA

**3061 DONNELLY DRIVE
LANTANA, FL 33462**

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A 081	Continued From page 7 technician training since receiving her initial 6-hour training on A review of Staff H's (MedTech/Personal Care Assistant) file revealed, Staff H's hire date was . Further review revealed Staff H had no documentation in file of the annual 2-hr continuing education for her medication technician training since receiving her initial 6-hour training on During an interview with Staff D (Business Office Manager, Corporate) on at 6:55 PM she was informed that the employee files were the pre-service orientation and in-service trainings respectively. Staff D stated she was aware that they were missing and that's why she was at the facility to correct the problem. Staff D acknowledged that all staff files needed to be audited to ensure compliance. She then stated she would work with the Administrator (Staff A) to ensure the care staff completed their pre-service and in-service trainings. Class III	A 081		

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ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	ZZ830		

AHCA Form 3020-0001

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ZZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	ZZ830			

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ZZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview, record review and observation, it was determined that, the facility failed to timely submit their request for approval of the Comprehensive Emergency Management Plan (CEMP), to the local emergency management agency, annually. The findings included: During an interview with the Staff E (Corporate Regional Representative) on at 12:45PM, she was informed to provide the facility's current CEMP approval letter. The Administrator stated the last approval CEMP letter was dated . A request was made to provide all communications, receipts and/or submissions she had regarding their CEMP. A review of the facility's provided letter from the Local Fire Safety Management Division dated , revealed an approval plan for the facility's Fire Safety plan. No proof of subsequent resubmissions of the CEMP to the County was provided during the survey. On at approximately 7:07 PM during, an interview with the Staff E (Corporate) she was informed that the documentation provided was the CEMP approval letter. Additionally, she was informed the facility has not submitted a CEMP since . Staff E stated she thought the documentation was for the CEMP. She further stated she would work with the new Administrator (Staff A) to get the CEMP submitted for 2025.	ZZ830			

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