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 |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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<br><br>An uannounced Relicensure, Generator Monitoring and Complaint (#2025018231 and #2026001592) survey was conducted at The Meridian At Lantana on . Deficiencies were identified at the time of survey. | A 000 | | |
| A 034 | 59A-36.007(9) ASSISTIVE DEVICES<br><br>(9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices.<br>(a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device.<br>(b) Documentation of each assistive device a resident uses must be included in the resident's record.<br>(c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment.<br>(d) All assistive devices must be clean, in good repair, and free of hazards.<br>(e) The facility must encourage and allow the resident to function with independence when using the assistive device.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to document the resident's use of an assistive device for 1 of 4 sampled residents ( Resident # 12 ).<br><br>The findings included: | A 034 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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 034 | Continued From page 1<br><br>In an interview conducted on at 9:27 AM with Resident # 12, she was observed sitting in a wheelchair. Resident # 12 stated that she is unable to ambulate without assistance.<br><br>In an interview conducted on at 3:25 PM with the Director of Nursing ( DON), she stated that Resident #12 is at high risk for , which is the reason she uses a wheelchair. She further stated that Resident #12 is unable to ambulate without assistance.<br><br>In an interview conducted on at 3:31 PM with Staff M ( LPN), she stated that Resident #12 requires assistance with all activities of daily living ( ADL's), except eating, , and toileting. She further stated that Resident #12 uses a wheelchair because she requires assistance to walk.<br><br>A record review of the Resident # 12 most recent health assessment ( AHCA Form 1823) provided by the DON revealed that the form was signed but not dated by the physician. Further review revealed that the resident's use of a wheelchair was not documented on the assessment.<br><br>Class III | A 034 | | |
| A 077 | 429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators<br><br>429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable | A 077 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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 077 | Continued From page 2<br><br>core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.<br><br>429.52<br>(4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.<br>(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.<br><br>59A-36.010<br>(1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter.<br>(a) An administrator must:<br>1. Be at least ; ;<br>2. If employed on or after , , have, at a minimum, a high school diploma or G.E.D.;<br>3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.;<br>4. Complete the core training and core | A 077 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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 077 | Continued From page 3<br><br>competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , , , are not required to take the competency test unless specified elsewhere in this rule; and,<br>5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department.<br>(b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must:<br>1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and,<br>2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility.<br>(c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to | A 077 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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 077 | Continued From page 4<br><br>assist in the operation and maintenance of those facilities.<br>(d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility.<br>(e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-09393.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on interviews and record reviews made at the time of survey, it was determined that, the facility failed to ensure that the Administrator complied with the core training competency test requirements as evidenced by her report that she failed the competency exam.<br><br>The findings included:<br><br>During an interview with the designated Admininistrator on at approximately | A 077 | | |

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 |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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 077 | Continued From page 5<br><br>10:12 AM, she stated that she is always in charge. She stated that staff will/can always call when they need help. She stated that she is not the admin they hired here as the Executive Director. She also stated she took the Core training and sat for the test but she did not pass. Further review revealed no evidence of the Core test Competency Exam passing score.<br><br>At at approximately 5:55 PM, in an exit interview with Staff J, it was identified that Staff A failed to complete the core requirements would result in a citation.<br><br>Class III | A 077 | | |

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 |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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 |
|---|---|---|---|---|
| ZZ830 | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning; emergency operations; inactive license.-<br>(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:<br>(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.<br>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.<br>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.<br>(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.<br>(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.<br>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider | ZZ830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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 |
|---|---|---|---|---|
| ZZ830 | Continued From page 1<br><br>is located in a geographic area in which a state of emergency was declared by the Governor if the provider:<br>1. Suffered damage to its operation during the state of emergency.<br>2. Is currently licensed.<br>3. Does not have a provisional license.<br>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.<br>(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.<br><br>(4) . . . Licensees providing residential or inpatient services must utilize an online database | ZZ830 | | |

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 |
|---|---|---|---|
| | AL11910382 | A. BUILDING: _____ B. WING _____ | 06/02/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE MERIDIAN AT LANTANA | 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 |
|---|---|---|---|---|
| ZZ830 | Continued From page 2<br><br>approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and an interview, it was determined that, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) revisions by the required deadline to the local county emergency management division.<br><br>The findings included:<br><br>During an interview on at approximately 10:00 AM with Staff J, the Business Office Manager, a copy of the CEMP approval letter was requested. She explained that the new CEMP was in process of being approved by the county. A request was made to provide all communications, receipts and/or submissions she had regarding their CEMP.<br><br>A review of the letter provided by Staff J, the Business Office Manager, from the Local Emergency Management Division dated revealed the CEMP was rejected and needed to be revised and resubmitted within 30 days of receipt of the letter.<br><br>During an Interview on at approximately 2:30 PM with Staff J, the Business Office Manager, confirmed that the facility has not resubmitted their CEMP revisions for approval and is aware the CEMP is currently expired. The facility provided no additional documentation for review at the time of the survey .<br><br>Class III | ZZ830 | | |