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
	AL11969030	A. BUILDING: _____ B. WING _____	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MERIDIAN AT WESTWOOD	1001 MAR WALT DR FORT WALTON BEACH, FL 32547

(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 survey for allegations contained within complaints 2019011955 and 2019013316 was conducted in conjunction with a Limited Nursing Services monitoring visit on through at The Meridian at Westwood. Deficient practice was identified at the time of this survey.	A 000		
A 025 SS=D	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 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, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, 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.	A 025		

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A 025	Continued From page 1 (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 record reviews and interviews, the facility failed to provide care and services to meet the needs of 1 of 4 residents sampled requiring assistance with self-administration of medications (#9) for 1 of 4 residents sampled receiving [redacted] (#9). The Findings Include: A record review was conducted for resident #9. The resident returned to the facility in following a stay at a skilled nursing facility. The Resident Health Assessment for Assisted Living Facilities, Form 1823, was completed and dated [redacted]. The document designated the resident as needing assistance with self-administration of medications. A review of the Medication Observation record (MOR) was conducted. The review revealed the resident did not get the ordered dose of [redacted] on [redacted] or [redacted]	A 025		

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A 025	Continued From page 2 On . . . . . at approximately 11:00 AM, an interview was conducted with the Executive Director (ED) who stated when resident #9 returned from the rehabilitation facility in of 2019, her form 1823 reflected the resident was documented as needing assistance with self-administration of medications. The ED stated a new service plan should have been done to reflect the residents needs for assistance with self-administration of medications. On at approximately 3:04 PM, a telephone interview was conducted with Nurse Consultant B who stated she had been informed of the concerns with resident 9's . . . . . . When the resident returned from the Skilled nursing facility she continued to self-administer medications until the residents daughter requested the facility assist her on . . . . . It was believed the error occurred because the facility did not have a Wellness Director and that is why the nurse consultant was in the building to take over the responsibilities until a new wellness director could be hired. Class III	A 025		