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
	AL11969956	A. BUILDING: _____ B. WING _____	C 06/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN AT BRANDON THE	9215 CAUSEWAY BLVD, PALM RIVER, FL 33619

(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 complaint investigation (complaint number: 2023006418) and a revisit to complaint investigation (complaint number: 2023004300) were conducted at Meridian at Brandon, The on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	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 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 must notify the resident's representative or designee of the need for health care services and must assist in making , , 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, including the following:	A 025		

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A 025	Continued From page 1 (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, record review, and interview, the Facility failed to provide the level of care and services required to meet the needs of residents who were . risks and required precautions three Residents (#1, #2, and #3) of three sampled residents that had frequent . . . Additionally, the facility failed to follow their . policy and procedures. Furthermore, the facility failed to respond to residents' requests for help in a timely fashion for three Residents (#25, #26, and #27) of three sampled residents. Findings Included:	A 025		

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A 025	Continued From page 2 During an observation, conducted on from 02:14pm through 02:29pm, an emergency call light in the hallway restroom on the second floor was pulled. At 02:15pm, an unidentified employee came out of the nearby medication room and walked down the hallway in the other direction of the restroom. At 02:20pm, an unidentified employee walked into the nearby laundry room carrying a stack of packages. The employee came out of the laundry room with a few packages and continued to deliver the packages to residents near the hallway restroom. At 02:29pm, there had been no staff that checked on the emergency call light to the second-floor hallway restroom. A record review for Resident #1, conducted on . . . . . , revealed that Resident #1 was admitted to the facility on . According to Resident #1's health assessment form dated , Resident #1 had diagnosis of , and . Resident #1 was fragile, poor vision, hearing loss, and was at risk of . There was no evidence that Resident #1 used an assistive device for ambulation. Resident #1 required assistance with ambulation, bathing, grooming, eating, toileting, and transferring. Resident #1 was sent to the hospital on related to an unwitnessed . On /023, Resident #1 was admitted to the hospital due to a sustained during another and continued in the hospital or rehabilitation facility because of the injuries sustained. Resident #1's Service Plan dated noted that Resident #1 used a wheelchair for ambulation, mobility, escorts, and transfers with assistance. There was one intervention for prevention noted on this	A 025		

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A 025	Continued From page 3 Service Plan which was to encourage Resident #1 to stay in common areas to promote more supervision. The Service Plan was not signed by Resident #1 or the resident's responsible party. There were no other Service Plans found in Resident #1's record. Resident #1's Assessments dated . . . . . and . . . . . noted that Resident #1 was at risk for . The . Assessments noted that Resident #1 had . . and used an assistive device for ambulation. The . Assessments noted that Resident #1 had adequate vision with or without glasses. There were no other . Assessments found in Resident #1's record. A review of history for Resident #1, conducted on . . . . . , revealed that Resident #1 had four from through . . . . . Resident #1's . . . were on , , , and . . . . . There was no evidence that the facility notified Resident #1's primary care provider of the resident's . on . . . . . There was no evidence that Resident #1's responsible party was notified of the resident's . on . A record review for Resident #2, conducted on . . . . . , revealed that Resident #2 was admitted to the facility on . According to Resident #2's health assessment form dated , Resident #2 had diagnosis of . . . . 's, ... , and . . . . Resident #2 was and at risk of . There was no evidence that Resident #2 used an assistive device for ambulation. Resident #2 required assistance with ambulation, bathing, , grooming, toileting, and transferring. Resident #2's Service Plan dated . . . . . noted that staff should remind Resident #2 to use	A 025		

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A 025	Continued From page 4 his assistive device for ambulation. The assistive device was not noted in the Service Plan. On [redacted], the Service Plan was updated to add wellness check. There was no description of the frequency of the wellness checks. There were no other interventions for [redacted] prevention noted in Resident #2's record. The Service Plan was not signed by Resident #2 or the resident's responsible party. There were no other Service Plans found in Resident #2's record. Resident #2's [redacted] Assessment dated [redacted] noted that Resident #2 was at risk for [redacted]. There were no other [redacted] Assessments found in Resident #2's record. A review of [redacted] history for Resident #2, conducted on [redacted], revealed that Resident #2 had thirteen [redacted] from [redacted] through [redacted]. Resident #2's [redacted] were on [redacted] at 05:16pm and 05:50pm, [redacted], [redacted] at 06:58am and 10:57pm, [redacted], [redacted], [redacted] at 12:02am and 04:23am, [redacted], and [redacted]. There was no evidence that the facility notified Resident #2's primary care provider or responsible party with the [redacted] that occurred on [redacted] at 08:37am. A record review for Resident #3, conducted on [redacted], revealed that Resident #3 was admitted to the facility on [redacted]. According to Resident #3's health assessment form dated [redacted], Resident #3 had diagnosis of [redacted], and [redacted]. Resident #3 had a poor memory and poor decision making. Resident #3 was not assessed as a [redacted] risk. There was no evidence that Resident #3 used an assistive device for ambulation. Resident #3 was independent with ambulation, eating, grooming, toileting, and transferring and required	A 025		

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A 025	Continued From page 5 supervision with [illegible] and assistance with bathing. Resident #3 had three Service dated [illegible], [illegible], and [illegible]. There were no interventions of [illegible] prevention noted on any of Resident #3's three Service Plans. The Service Plan was not signed by Resident #3 or the resident's responsible party. There were no other Service Plans found in Resident #3's record. Resident #3's [illegible] Assessment dated [illegible] noted that Resident #3 was at risk for [illegible]. There were no other [illegible] Assessments found in Resident #3's record. A review of [illegible] history for Resident #3, conducted on [illegible], revealed that Resident #3 had twelve [illegible] from [illegible] through [illegible]. Resident #3's [illegible] were on [illegible], and [illegible]. There was no evidence that the facility notified Resident #3's primary care provider related to the [illegible] that occurred on [illegible] at 04:27am, [illegible] at 08:30pm, [illegible] at 03:19am, and [illegible] at12:42pm. There was no evidence that the facility notified Resident #3's responsible party related to the [illegible] that occurred on [illegible] at 04:27am, [illegible] at 12:20am, [illegible] at 10:22pm, [illegible] at 02:05am, and [illegible] at 03:19am. A review of the facility's [illegible] history, conducted on [illegible], revealed that facility residents had one hundred and fifty twenty-one [illegible] from [illegible] through [illegible]. There were twenty-four [illegible] in [illegible]. There were twenty-three [illegible] in [illegible]. There were thirty-five [illegible] in [illegible]. There were thirty-nine [illegible] in [illegible]. There were thirty [illegible] in [illegible].	A 025		

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A 025	Continued From page 6 A review of the computer data for call light response, conducted on . . . . . , revealed that call lights were not answered within a timely manner on . . . . . from 12:00pm through 03:00pm. There was no evidence that the second-floor hallway restroom's emergency light was pulled. The light did not register as on in the call light system. Resident #25's call light was on for thirty minutes. Resident #26's call light was on for twenty-seven minutes. Resident #27's call light was on for twenty minutes. A review of the facility's policy and procedure reviewed and updated on . . . . . entitled ' ', conducted on , revealed that the facility was to assess residents regarding risk before and at aadmission, after each , at each required assessment, and following a significant change. The policy and procedure noted that the facility would use ordered interventions as well as other known accepted industry interventions to reduce the risk of . . . The facility was to educate and communicate interventions to the residents and/or the resident's responsible party. The facility was to notify the resident's primary care provider and responsible party with each . The facility was to perform a risk assessment with each . The facility was to update the resident's Service Plan with interventions for prevention with each and have the resident and/or responsible party sign the Service Plan. The facility was to reassess resident with for appropriate supervision and that interventions were in place. In event of repetitive , the facility was to implement additional interventions to reduce the risk of and if there were continued despite interventions, the facility was to review the residency criteria to determine the	A 025		

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A 025	Continued From page 7 appropriateness of residency. During an interview with the Wellness Director, conducted on at 04:01pm, the Wellness Director agreed that Resident #1, #2, and #3's Service Plans and Assessments were not updated according to the facility's policy and procedures. The Wellness Director agreed that there were incidents for Residents #1, #2, and #3 that did not have notifications to their primary care providers and responsible parties. The Wellness Director stated that Resident #3 used a four-wheeled walker. The Wellness Director agreed that the facility had no evidence that interventions were implemented for reductions with each that Residents #1, #2, and #3 had. During an interview with the Executive Director, conducted on at 02:52pm, the Executive Director stated that call lights were to be responded to within fifteen minutes. At 03:25pm, the Executive Director agreed that it appeared that there were issues with call lights being checked on in a timely manner. The Executive Director stated that after further review of the call light for the second-floor hallway restroom found that the call light showed up as in the call system and not as the hallway restroom. Class III	A 025		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting	A 083		

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A 083	Continued From page 8 completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide staff on each shift with training in , , ( ) and First Aid (FA). Findings Included: An employee record review for Staff D, F, G, H, and J, conducted on , revealed that Staff D, F, G, H, and J did not have evidence of training for and FA in their employee records. Staff D was hired on . Staff F was hired on . Staff G was hired on . Staff H was hired on . Staff I was hired on . Staff J was hired on . A review of the staffing schedule, conducted on , revealed that on , Staff D	A 083		

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A 083	Continued From page 9 worked with Staff G on the 10:00pm through 06:00am shift with no other staff on duty for that shift. On . . . . . , Staff F worked with Staff G on the 10:00pm through 06:00am shift with no other staff on duty for that shift. On . . . . . , Staff D worked with Staff F on the 10:00pm through 06:00am shift with no other staff on duty for that shift. On . , Staff D worked with Staff G on the 10:00pm through 06:00am shift with no other staff on duty for that shift. On . . . . . , Staff D worked with Staff J on the 10:00pm through 06:00am shift with no other staff on duty for that shift. On . . . . . , Staff D worked with an Agency Staff on the 10:00pm through 06:00am shift with no other staff on duty for that shift. During an interview with the Executive Director, conducted on . . . . . at 11:39am, the Executive Director stated that Staff G did not have . and FA training. At 12:35pm, the Executive Director stated that H did not have . and FA training and agreed that Staff D and F did not have evidence of and FA training in their employee records. At 03:56pm, the Executive Director stated that Staff J did not have and FA training. The executive director provided a and FA training certificate for the Agency Staff. There was no evidence that the Agency Staff's and FA training was approved or accredited by the American . . Association, the American Red Cross, or the National Safety Council. Class III	A 083		