

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966541</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/09/2024</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**MEADOW WOOD HOMES LLC**

**25799 SW 122 PLACE  
HOMESTEAD, FL 33032**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>A re-licensure biennial survey, with a limited mental health component, was conducted at Meadow Wood Homes, LLC on . The provider had a deficiency identified at the time of the survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | A 000               |                                                                                                                          |                          |
| A 054<br>SS=D            | 59A-36.008(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use.<br>(b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include:<br>1. The name of the resident and any known the resident may have;<br>2. The name of the resident's health care provider and the health care provider's telephone number;<br>3. The name, strength, and directions for use of each medication; and,<br>4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.<br>(c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the | A 054               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
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|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 054                    | <p>Continued From page 1</p> <p>medication.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on interview and record review, the facility failed to maintain an accurate daily medication observation record (MOR) for each resident who receives assistance with self-administration and administration of medications that include any known _____ the resident may have, the telephone number of the resident's health care provider and directions for use of each medication for one out of six sampled residents (Resident #4).</p> <p>Findings included:</p> <p>Review of the MOR for Resident #4 showed the telephone number of the residents' health care provider was not documented nor was indicated whether or not the resident had any _____. Additionally, the MOR did not show a specific time for the medications, instead it was listed as AM or PM.</p> <p>On _____ at 1:43 PM, during a telephone interview, the Administrator stated that she would ensure the MOR was completed.</p> <p>Class III</p> | A 054               |                                                                                                                          |                          |