

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969476	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/19/2024
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MEDITERRANEAN ASSISTED LIVING FACILITY CORP

**4427 MEDITERRANEAN RD
LAKE WORTH, FL 33461**

(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 and Generator Monitoring survey was conducted on at Mediterranean Assisted Living Facility Corp. The facility had a deficiency identified at the time of the survey.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (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. (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: 1. The name of the resident and any known _____ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (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

(X8) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969476	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER MEDITERRANEAN ASSISTED LIVING FACILITY CORP		STREET ADDRESS, CITY, STATE, ZIP CODE 4427 MEDITERRANEAN RD LAKE WORTH, FL 33461		
(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 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on record review and an interview, it was determined that the facility failed to ensure the Medication Observation Record (MOR) was completed as required for 1 out of 6 sampled residents (Residents #4) who required assistance with self-administration of medication. The findings included: During review of the MOR's, the following omissions and errors were identified: 1) Resident #4 a. 10 MG Tabs medication was initialed as given daily from through , except . This medication was to be given on at 9:00AM. During interview with the Administrator at 10:45 AM on , there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR. b. 5 MG tab was initialed as given daily from through , except . This medication was to be given on at 9:00AM. During interview with the Administrator at 10:45 AM on , there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR. c. 20MG tabs was initialed as given	A 054		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969476	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER MEDITERRANEAN ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 4427 MEDITERRANEAN RD LAKE WORTH, FL 33461		
(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 054	Continued From page 2 daily from _____ through _____, except This medication was to be given on _____ at 9:00AM. During interview with the Administrator at 10:45 AM on _____, there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR. d. 400MG CAPS was initiated as given daily from _____ through _____ ,except This medication was to be given on _____ at 8:00AM. During interview with the Administrator at 10:45 AM on _____ , there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR. e. 4% PTCH was initiated as given daily from _____ through _____,except This patch was to be applied on _____ at 9:00AM. During interview with the Administrator at 10:45 AM on _____, there was no patch observed for this resident. She acknowledged that the resident's patch was applied by Staff B, but she didn't sign the MOR. f. 500MG TABS was initiated as given daily from _____ through _____ except This medication was to be given on _____ at 8:00AM. During interview with the Administrator at 10:45AM on _____ there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR.	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969476	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER MEDITERRANEAN ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 4427 MEDITERRANEAN RD LAKE WORTH, FL 33461		
(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 054	Continued From page 3 g. Multi-Vite Liquid was initialed as given daily from _____ through _____, except _____ This medication was to be given on _____ at 9:00AM. During interview with the Administrator at 10:45 AM on _____, there were evidence that this medications had been administered. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR. h. Pregabalin 100 MG Caps was initialed as given daily from _____ through _____, except _____ This medication was to be given on _____ at 8:00AM. During interview with the Administrator at 10:45 AM on _____, there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR. i. _____ 50 MG T was initialed as given daily from _____ through _____, except _____ This medication was to be given on _____ at 7:00AM. During interview with the Administrator at 10:45 AM on _____, there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR. j. _____ 50 MG Tabs was initialed as given daily from _____ through _____, except _____ This medication was to be given on _____ at 8:00AM. During interview with the Administrator at 10:45 AM on _____, there were no pills observed while reviewing the supplied bubble packs of medication for this	A 054			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969476	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER MEDITERRANEAN ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 4427 MEDITERRANEAN RD LAKE WORTH, FL 33461		
(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 054	Continued From page 4 resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR.. k. C 500 MG Tab was initiated as given daily from through , except This medication was to be given on at 9:00AM. During interview with the Administrator at 10:45 AM on , there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR.. l. 50MG Tabs was initiated as given daily from through , except . This medication was to be given on at 9:00AM. During interview with the Administrator at 10:45 AM on , there were no pills observed while reviewing the supplied bubble packs of medication for this resident. She acknowledged that the resident was given the medication by Staff B, but she didn't sign the MOR.. Class III	A 054			