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 _____	10/02/2025

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
ZZ875 SS=D	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each	ZZ875		

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ZZ875	Continued From page 1	ZZ875		

employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information,

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ZZ875	Continued From page 2 and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year. (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.	ZZ875		

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ZZ875	Continued From page 3 (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , must complete the training required in this section before , . Proof of completion of equivalent training completed before , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of completing the one-hour and Related Forms of Training within 30 days of hire for one of five (Staff A) sampled employee records. Findings included: A record review conducted on revealed that Staff A's record did not include verification of completing the 's and Related Forms of Training within 30 days of hire. Staff A was hired on . During an interview conducted on at	ZZ875		

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ZZ875	Continued From page 4 1:06pm, the Business Office Manager stated that she did not have access to the facility's training system since the system was under maintenance. She was unable to provide evidence of staff training record. Class III	ZZ875		

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A 000	Initial Comments A complaint investigation (2025013743 and 2025014703) was conducted at The Meridian at Brandon on . Deficiencies were identified at the time of the survey. A Class I deficiency was found at Tag A0036. A Class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, , , or to a resident receiving care in a facility. The Meridian at Brandon failed to implement control standards to prevent the development and spread of , an , within the facility's water systems. The Class I noncompliance began on . The facility's Administrator was notified of the Class I noncompliance on at 4:30 p.m. The census at the start of the survey was 139. The following is a description of the deficiencies found at the time of the visit.	A 000		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or	A 032		

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A 032	Continued From page 1 with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:	A 032		

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A 032	Continued From page 2 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of facility's Elopement Response Trianing for one of five (Staff A) sampled employee records. Findings included: A recorded review conducted on revealed that Staff A's record did not include facility's Elopement Response Trianing. Staff A was hired on . During an interview conducted on at 1:06pm, the Business Office Manager stated that she did not have access to facility training system since the system was under maintenance. She was unable to provide evidence of Staff A's training record. Class III	A 032		

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A 036	Continued From page 3	A 036		
A 036 SS=L	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or , . hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement control remedies to control and prevent transmission of , an . The facility's lack of urgency to implement control standards after a known outbreak directly , two (Resident #1 and Resident #2) of two sampled	A 036		

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A 036	Continued From page 4 residents that continued to reside in rooms that tested positive for the . The facility's lack of action to implement immediate safety precautions and remediation efforts placed 139 of 139 facility residents at risk of exposure to , which can cause severe , , illness and/or . Findings included: On from 9:20 a.m. an interview was conducted with the Executive Director who stated a state health organization had inspected the facility and found two rooms that were positive for the . Resident #1's room sink tested positive for the and Resident #2's room shower tested positive for the . He stated the facility had retested the positive rooms and the rooms directly adjacent to the positive rooms but did not yet have results. He stated there were no residents in the affected rooms. He said the facility had been running the water in the rooms weekly to flush them. Additionally, he stated the state health organization's recommendations would cost approximately $250,000, dollars and the health organization was not working with them on the recommendations. Furthermore, he felt that if the results from their independent company testing came with negative results that the facility corporate team would inquire if they had to implement the local health organization's recommendations. He stated he had nothing in writing from the [city water company] about chlorination of water for the and did not think to ask for it. On , a review of the facility census records revealed Resident #2 resided in the room	A 036		

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A 036	Continued From page 5 that tested positive for the in the shower from to , and Resident #1 resided in the room that tested positive for the in the sink from to . On a review of a control organization's link dated found online at https://www.cdc.gov/ /about/index.html revealed Legionnaires' is a serious type of , caused by . - People can get the by breathing in mist or small water droplets, or by swallowing water containing into the . - People with health conditions such as , , , , failure, weak systems, , , , , anyone on some medications that weaken the system, those over , and current or former smokers are at increased risk. - Factors that lead to growth included Biofilm (slime that provides a place for germs to grow), certain temperatures (77°F-113°F), not having enough or slow or no water movement. - Legionnaires' symptoms included , , , , aches, , , and . - The key to preventing Legionnaires' is to control growth and spread. - Buildings at increased risk for growth and spread should have a water management program based on industry standards. - A link attached to the article found online at https://www.cdc.gov/ /infographics/legion -affects-water-systems.pdf listed how affects building water systems and people. #2 listed grows best in large,	A 036		

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A 036	Continued From page 6 , water systems that are not adequately maintained and then aerosolized through devices such as cooling towers, showers, hot tubs and fountains. On a record review of a state health organization letter dated was addressed to the facility Executive Director. The letter was related to a follow-up site visit conducted on which revealed the following: "The onsite assessment conducted by the [state health organization] on did indicate conditions in the premise plumbing that could harbor and breed biofilms and ." The [state health organization] made the following recommendations: 1. We recommend that you obtain professional consultation from a qualified water systems expert, for proper assessment and remediation of your water system. The remediation action plan must be reviewed by [state health organization] and results of the follow up monitoring must be provided to [state health organization]. We have attached some accepted remediation and maintenance guidelines for your information and consideration. 2. We recommend post-remediation testing following a detailed plan such as [state safety health organization] remediation schedule below, entitled "Test the domestic hot or warm water system for " on the following schedule: a. Weekly for the first month after resumption of operation b. Every two weeks for the next two months. c. Monthly for the next three months. If 10 or more Colony Forming Units (CFU) per milliliter of water are present, re-treat the system. Resume weekly testing after treatment. If levels	A 036		

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A 036	Continued From page 7 remain below 1 CFU per milliliter, no further monitoring is necessary. If the levels are between 1 and 9 CFU per milliliter, continue monthly sampling of the water indefinitely and continue efforts to determine the source of contamination." 3. We recommend that [Facility name] either install 0.2-micron biological point-of-use filters on any showerheads or sink/tub faucets intended for use until remediation of your premise plumbing has occurred or restrict the use of showers to reduce the risk to guests during this investigation until further notice. 4. We recommend that [Facility name] notify incoming residents as well as current residents and their families in writing about the ongoing investigation of Legionnaires' . Management should contact residents who stayed at [Facility Name] in the last four weeks (starting to present) to notify them about the ongoing investigation of Legionnaires' cases associated with the facility. This provides residents with an opportunity to make an informed decision based on their personal assessment of risk; and an opportunity to seek medical care appropriately should they become ill with symptoms of , . 5. For maintenance of the premise plumbing system and to minimize growth of , domestic hot water should be stored at a minimum of 140 degrees Fahrenheit and delivered at a minimum of 122 degrees Fahrenheit to all points of delivery. Minimum temperature of 122 degrees is required to prevent new growth of within hot water systems. We recommend installing a mixing valve on the heat exchangers so the hot water supply can be stored at 140 degrees Fahrenheit and then discharged at 120 degrees Fahrenheit to comply with guidelines. 6. It is also recommended that your facility	A 036		

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A 036	Continued From page 8	A 036		

monitor hot water temperatures at locations from the boilers/hot water heaters. Annual inspections of the entire water system are advisable. These should include periodic draining, cleaning with a solution, and flushing of all water storage tanks to remove biofilm, scale and sediment. The importance of maintaining complete documentation of the facility premise plumbing maintenance, water management efforts, and temperature logs cannot be overstated.
7. Report all possible cases of Legionnaires' (staff or residents) immediately to the [local agency tracking phone number]. Please continue to use confirmatory testing methods for the diagnosis of via , culture or [molecular testing acronym] from lower , specimens.
8. Develop a written water safety management plan for the prevention and control of . Attachments included "Domestic Hot Water Systems: Emergency Management and Best Practices" steps for Pasteurization, Chlorination, and maintenance after decontamination that includes references and links for resources/information.

On a record review of the facility insurance reporting forms dated from to revealed the following documentation:
- - with an occurrence date of : Resident #2 was found on the floor by staff after pushing pendant after hitting and could not speak clearly asking "where am I?" Furthermore, the form revealed Resident #2 "showed signs of , and was tested with positive results of ."
- - with an occurrence date of : A discussion occurred with a state

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A 036	Continued From page 9 Insurance health organization on regarding conditions in premise plumbing that could harbor and breed biofilms and with two or more confirmed cases of Legionnaires from reported exposure at the facility between and . On a record review of the facility's water temperature log from to revealed the following temperatures that were below the health organization's recommended minimum water temperature of 122 degrees Fahrenheit: - : temperatures listed between 118.1 to 119.6-degrees Fahrenheit - : temperatures listed between 117.3 to 119.6-degrees Fahrenheit - : temperatures listed between 117.9 to 119.6-degrees Fahrenheit - : temperatures listed between 115.6 to 119.8-degrees Fahrenheit On from 10:54 a.m. an interview was conducted with the Executive Director. The Executive Director denied notification in writing to a total of eleven new residents (Resident #3-Resident #13) admitted after . Additionally, the Executive Director stated the [environmental engineering company] proposal was sent to corporate to sign but they did not, so the Executive Director signed the second proposal. The Executive Director stated filters were ordered but had not arrived and there were complaints about the $119,000 dollar price. The Executive Director stated the [state health organization] recommendation for testing would be approximately $32,000 dollars a visit and was not completed. The Executive Director stated they had to "play with the valve" to get the water	A 036		

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A 036	Continued From page 10 temperature to dispense at 122 degrees and the [state health organization] recommendations had not been completed. The Executive Director stated [Resident #3] , , under , care after a positive test result and [Resident #4] moved out after a positive test result. Resident #2 was not tested but had , , . Furthermore, The Executive Director agreed the staff should have followed up with the hospital on testing since Resident #2 was readmitted to the facility into the same room that tested positive for the . On a review of the facility admission log revealed admissions from to for the following: - Resident #3 on - Resident #4 on - Resident #5 on - Resident #6 on - Resident #7 on - Resident #8 on - Resident #9 on - Resident #10 on - Resident #11 on - Resident #12 on - Resident #13 on On a record review of a testing results letter from the [state health organization] dated revealed positive testing results of specimens with , , in the sink of Resident #1's room and the shower of Resident #2's room. On a record review of an unsigned proposal from [environmental engineering company] dated for initial baseline sampling revealed sample locations proposed as municipal supply water,	A 036		

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A 036	Continued From page 11 twelve hot water tanks, two beauty salons, water softener, Resident #2's room in assisted living, Resident #1's room in memory care, assisted living showers, assisted living kitchen sinks, assisted living bathroom sinks, memory care showers, memory care bathroom sinks, utility closets, and ice machines with a total of 15 swabs to be collected in Resident #2's room, and Resident #1's room for a total proposed cost of $32,000 dollars. On a record review of a signed proposal from [environmental engineering company] dated revealed Resident #2's room for six samples and adjacent rooms on either side of that room for 12 samples, Resident #2's room for four samples and eight samples taken on rooms on either side for a total proposed cost of $15,075.00. The proposal was signed by the Executive Director on . On a review of the city water company customer request laboratory report dated revealed residual, temperature and total coliform results showed the samples met guidelines for safe drinking water. No other routine sampling testing or results were provided. On at 11:14 a.m. the Maintenance Director stated they had the facility water temperature set to 140 degrees Fahrenheit but could not adjust the temperature to come down to 122 degrees Fahrenheit for dispensing and would need to have someone come in to replace the mixing valve. The Maintenance Director said the facility had not done this because they were waiting to see what was happening. Additionally, the Maintenance Director said housekeepers ran water in the rooms weekly, but there was nothing	A 036		

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A 036	Continued From page 12 in writing and they would just verbally report it. On a record review of an email between the state health organization and the facility's Executive Director that included forwarded emails between the facility and the environmental engineering company revealed an ongoing pattern of delay and lack of timely implementation of required remediation measures: - : The state health organization notified the facility in writing after a phone conversation that two Legionnaires' cases were identified among residents, provided recommendations that noted the population as "advanced age and patients". An environmental assessment was warranted, and a request was made for a copy of the facility's water safety plan. - : The state health organization emailed the Executive Director requesting an update regarding the state health organization recommendations as they awaited the laboratory testing of samples collected on site. - - : The state health organization followed up for a status updates; the Executive Director inquired if prior correspondence addressed the issue but provided no evidence of completed remediations. - - : An email from the environmental engineering company obtained by the facility was forwarded from the facility to the state health organization and showed information gathering was still "in progress," and a sampling strategy and mitigation plan had not yet been finalized. The vendor noted it would be "polling around through our regional people and local ones to provide the services you need. For now, send me the state notice that you have and we	A 036		

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A 036	Continued From page 13	A 036		

will go from there." The vendor then marked only information gathering as in progress of the state recommendations sent to the facility.

- - : The state health organization requested confirmation of an action plan twice. The Executive Director responded that several items remained "in progress," including sampling strategy development, baseline sampling, water system mitigation plan, point of use filter order pended approval, written water management program, and post-mitigation.

- : The state health organization representative sent an email to the Executive Director and inquired about an update on the post assessment remediation implemented and results of any testing completed.

- On at 4:37 p.m. the Executive Director emailed the state health organization representative the following items that were not documented or provided on survey:

a. Environmental engineering company] was on site testing Tuesday and Wednesday ( ) and completed the following with an expected 10-14-day timeframe for testing results.

b. 15 swab samples were collected from inside the sink and showerhead pipes in the units where previous positive results were identified, in addition to units adjacent to [Resident #1's] room and [Resident #2's] room.

c. Measure total , free , pH, and water temperature at sampling sites.

e. We have been flushing and will continue to flush the system weekly and turn shower heads after usage."

On at 11:26 a.m. a phone interview with a state health organization representative was conducted. The representative stated the city water report was just a report of water ph. levels and not the concern. The

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A 036	Continued From page 14 representative said it was not recommended that new residents be put into the two rooms which tested positive, which were occupied by Resident #1 and Resident #2. The representative stated there was no evidence provided that the facility had or hyperchlorination in their water management plan and everyone was at risk. The representative said the facility had taken three months and had not taken any definitive action. On at 2:24 p.m. a follow up interview was conducted with a state health organization representative. The representative stated Resident #2 was a probable case that never tested positive but had all the symptoms. Resident #2 had a diagnosis and had likely already started when testing was completed for . Additionally, the state health organization representative stated they would want the facility to run tests on anyone with , issues to rule out . The state health organization representative said they had not seen a water safety management plan and the [environmental engineering company] sent an action plan but it was very different than a water management plan. The state health organization representative stated that the city water test results showed parameters at one point in time, but the facility should have continued to do their own monitoring and kept records. The state health organization representative also stated that the running water flushes were not sufficient if point-of-use filters were not installed. Additionally, the state health organization representative said the facility had no monitoring in place and the state health organization had been trying to work with the facility since , but the facility did not follow the testing schedule, install filters or complete any action recommended for remediation.	A 036		

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Furthermore, the state health organization representative said samples from Resident #1's room and Resident #2's room and those rooms directly adjacent by the [environmental engineering company] as reportedly sampled would not be enough when the entire plumbing system could be affected.

On at 12:23 p.m. an interview conducted with the Director of Wellness. The Director of Wellness stated Resident #2 was admitted in , and had been in a room that tested positive for since admission. The Director of Wellness said Resident #2 went to the hospital on and returned on before returning to the hospital due to inability to sit up or walk due to . The Director of Wellness said Resident #2 had a confirmed diagnosis of , on but there was no record of testing on file for Resident #2's hospitalization. The Director of Wellness reported Resident #1 moved into a room that tested positive for when Resident #3 went to care and . Additionally, The Director of Wellness stated there were Coronavirus of 2019 (COVID) positive cases in memory care and one case in assisted living that had not been tested for but due to surveyor questions the facility had contacted the lab to come test the nine residents. Furthermore, the Director of Wellness stated the facility management had told the staff that running the water in the room would be okay for the outbreak.

On a record review of a list of residents that presented , symptoms and tested positive for COVID was conducted. There was a total of nine cases that tested

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A 036	Continued From page 16 positive for COVID between and . Eight were on memory care and one resided in assisted living. On at 1:59 p.m. an interview was conducted with the Wellness Coordinator who stated residents with coughing and were tested for COVID. On documentation of tracking residents with signs and symptoms of problems/concerns was requested but not provided. On a record review for Resident #4 revealed on the resident was found on the bathroom floor and unable to say what happened and sent to the hospital for evaluation. On notes revealed the hospital electronic system notes showed Resident #4 had abnormal lab work and had and consults ordered. On notes revealed the hospital records showed resident with " Ag +" and to be continued on with a recommendation for inpatient rehabilitation and home . Resident #4 was discharged from the facility . On a record review for Resident #3 revealed the following: - resident #3 was found in common area, very and not easily aroused and sent by ambulance to the hospital for evaluation and returned. - On staff heard a scream from a room and found resident #3 sitting on the floor. Family of Resident #3 refused transport to hospital. - On resident #3 began with	A 036		

Agency for Health Care Administration

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behaviors and refused to eat.
- On the resident #3 was weak, flushed and sent to the hospital and did not return.
- notes regarding updates from hospital provider and family revealed Resident #3 had a diagnosis of double , with , care recommended.
- notes revealed the facility was informed that Resident #3 , on , care.

On a record review for Resident #1 revealed an admission date of . Resident #1 was and was relocated to the room that tested positive for the after Resident #3 , in . Resident #1 had diagnoses of Type II , unspecified , , history, and essential .

On a record review for Resident #2 revealed an admission date of . Resident #2 was and lived in a room that tested positive for the since admission. Resident #2 had diagnoses that included but were not limited to unspecified with acute exacerbation, 's , acute , , generalized , dependence on supplemental , , , and . Facility notes dated revealed Resident #2 was found overnight when Resident #2 pushed the call pendant and staff entered room and found resident on the floor, unable to speak clearly and asked where they were. Resident #2 was in the hospital from

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A 036	Continued From page 18 /2025 and returned to facility on but was unable to stand, sit up or walk, was very weak on 2 liters of ,, . Resident #2 went to the hospital on . On at 12:11p.m. an observation of Resident #2's was conducted. There were two small ,, tanks on stands in the room and resident was not present. On at 12:16 p.m. an interview was conducted with Resident #2. Resident #2 stated an admission date of and reported a hospital visit for , and reported lifelong and nighttime ,, use. On a record review of the facility Control Policy and Procedure with revised date of , reviewed date of and reformatted date of revealed; "Policy: The community will make a reasonable attempt to minimize the risk and/or spread of communicable for the mutual protection of residents, families, staff and the public. The community will ensure staff will be training in working with residents who have an , preventative and control measures, reporting and documentation requirements. Local, county and state mandates will supersede this policy. Unless otherwise specified by the regulatory agency, an outbreak will be quantified as ten (10) percent of the community population. In an outbreak the community may be subject to various shut down protocols to mitigate additional spread of . The Executive Director will ensure the control policy is in place."	A 036		

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A 036	Continued From page 19 Photographic evidence obtained. Class I	A 036		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of	A 081		

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A 081	Continued From page 20 completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when	A 081		

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A 081	Continued From page 21 offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement	A 081		

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A 081	Continued From page 22 response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure four of five (Staff A, Staff B, Staff C, and Staff D) sampled employee files contained verification of in-services training completion. The facility failed to ensure Staff A, Staff B, Staff C and Staff D obtained training in Adverse Incident Training, and Facility Emergency Response Training. Also, the facility failed to ensure (Staff D) obtained Control Training. Findings included: A personnel recorded review conducted on revealed the following: "Staff A, Staff B, Staff C, and Staff D's record did not include evidence of completing adverse incident and facility emergency response training. "Staff D's record did not include Control Training. Staff A was hired on . Staff B was hired on . Staff C was hired on . Staff D was hired on .	A 081		

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A 081	Continued From page 23 During an interview conducted on at 1:06pm, the Business Office Manager stated that she did not have access to facility training system since the system was under maintenance. She was unable to provide evidence of staff training records. Class III	A 081		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.	A 162		

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 _____	10/02/2025

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 162	Continued From page 24 (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A ⌣ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their ⌣ recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that ⌣ not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S.	A 162		

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 _____	10/02/2025

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 162	Continued From page 25 (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , . , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.	A 162		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 162	Continued From page 26 (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on interview and record review the Facility failed to maintain a completed copy of the Resident Health Assessment Form (1823) for one (Resident #1) of three sampled residents. Findings included: On a record review for Resident #1 was conducted. Resident #1's 1823 did not list the facility zip code on page 1. Under the examiner section marked with "Medical certification is incomplete without the following information": the date of examination was blank. On at 4:30 p.m. an interview was conducted with Wellness Director. The Wellness Director Resident #1's 1823 was incomplete. (Photographic evidence obtained) Class III	A 162		