

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340		
(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 On _____, an unannounced biennial survey (including Limited Mental Health and Limited Nursing Services) was conducted at Meadowlands Senior Living Assisted Living Facility. At the time of survey there were deficiencies identified.	A 000		
AL241 SS=D	58A-5.029(2) FAC LMH - Records (2) RECORDS. (a) A facility with a limited mental health license shall maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all mental health residents. The admission and discharge log required under Rule 58A-5.024, F.A.C., shall be sufficient provided that all mental health residents are clearly identified. (b) Staff records shall contain documentation that designated staff have completed limited mental health training as required by Rule 58A-5.019, F.A.C. (c) Resident records for mental health residents in a facility with a limited mental health license must include the following: 1. Documentation, provided by the Department of Children and Family Services within 30 days of the resident's admission to the facility, that the resident is a mental health resident. Documentation that the resident is receiving social security _____ or supplemental security income, _____, and any of the following shall meet this requirement. a. An affirmative statement on the Alternate Care Certification for _____ () Form, CF-ES 1006, _____, 1998, that the resident is receiving SSI/SSDI due to a _____ b. Written verification provided by the Social	AL241		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0809

E60D11

If continuation sheet 1 of 14

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340			
(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
AL241	Continued From page 1 Security Administration that the resident is receiving SSI or SSDI for a mental Such verification may be acquired from the Social Security Administration upon obtaining a release from the resident permitting the Social Security Administration to provide such information to the Department of Children and Family Services. c. A written statement from the resident 's case manager that the resident is an adult with severe and persistent mental illness. The case manager shall consider the following minimum criteria in making that determination. (i) The resident is eligible for, is receiving, or has received state funded services from the Department of Children and Family Services ' and Mental Health program office within the last 5 years; or (ii) The resident has been diagnosed as having a mental 2. An appropriate placement assessment provided by the resident 's mental health care provider within 30 days of admission to the facility that the resident has been assessed and found appropriate for residence in an assisted living facility. Such assessment shall be conducted by a psychiatrist, clinical psychologist, clinical social worker, or nurse, or person supervised by one of these professionals. a. Any of the following documentation which contains the name of the resident and the name, signature, date, and license number, if applicable, of the person making the assessment, shall meet this requirement: (i) Completed Alternate Care Certification for (.) Form, CF-ES Form 1006, 1998; (ii) Discharge Statement from a state mental hospital completed within 90 days prior to admission to the ALF provided it contains a statement that the individual is appropriate to live	AL241			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340			
(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
AL241	Continued From page 2 in an assisted living facility; or (iii) Other signed statement that the resident has been assessed and found appropriate for residency in an assisted living facility. b. A mental health resident returning to a facility from treatment in a hospital or crisis stabilization unit (CSU) will not be considered a new admission and not require a new assessment. However, a break in a resident 's continued residency which requires the facility to execute a new resident contract or admission agreement will be considered a new admission and the resident 's mental health care provider must provide a new assessment. 3. A Community Living Support Plan. a. Each mental health resident and the resident ' s mental health case manager shall, in consultation with the facility administrator, prepare a plan within 30 days of the resident 's admission to the facility or within 30 days after receiving the appropriate placement assessment under paragraph (c), whichever is later, which: (i) Includes the specific needs of the resident which must be met in order to enable the resident to live in the assisted living facility and the community; (ii) Includes the clinical mental health services to be provided by the mental health care provider to help meet the resident 's needs, and the frequency and duration of such services; (iii) Includes any other services and activities to be provided by or arranged for by the mental health care provider or mental health case manager to meet the resident 's needs, and the frequency and duration of such services and activities; () Includes the _____ of the facility to facilitate and assist the resident in attending appointments and arranging transportation to appointments for the services and activities	AL241			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340			
(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
AL241	Continued From page 3 identified in the plan which have been provided or arranged for by the resident ' s mental health care provider or case manager; (v) Includes a description of other services to be provided or arranged by the facility; (vi) Includes a list of factors pertinent to the care, safety, and welfare of the mental health resident and a description of the signs and symptoms to the resident that indicate the immediate need for professional mental health services; (vii) Is in writing and signed by the mental health resident, the resident ' s mental health case manager, and the ALF administrator or manager and a copy placed in the resident ' s file. If the resident refuses to sign the plan, the resident ' s mental health case manager shall add a statement that the resident was asked but refused to sign the plan; (viii) Is updated at least annually; (ix) include the Agreement described in subparagraph 4. If included, the mental health care provider must also sign the plan; and (x) Must be available for inspection to those who have a lawful basis for reviewing the document. b. Those portions of a service or treatment plan prepared pursuant to Rule 65E-4.014, F.A.C., which address all the elements listed in sub-subparagraph a. above may be substituted. 4. Agreement. The mental health care provider for each mental health resident and the facility administrator or designee shall, within 30 days of the resident ' s admission to facility or receipt of the resident ' s appropriate placement assessment, whichever is later, prepare a written statement which: a. Provides procedures and directions for accessing emergency and after-hours care for the mental health resident. The provider must	AL241			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340		
(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
AL241	Continued From page 4 furnish the resident and the facility with the provider's 24-hour emergency crisis telephone number. b. Must be signed by the administrator or designee and the mental health care provider, or by a designated representative of a Medicaid prepaid health plan if the resident is on a plan and the plan provides behavioral health services under Section 409.912, F.S. c. cover all mental health residents of the facility who are clients of the same provider. d. be included in the Community Living Support Plan described in subparagraph 3. Missing documentation shall not be considered a deficiency if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Family Services, or the mental health care provider under contract to provide mental health services to clients of the department. This Statute or Rule is not met as evidenced by: Based on staff interview and record review the facility failed to maintain an up-to-date admission and discharge log containing the names and dates of admission and discharge for all 5 mental health residents. The Findings: On : a biennial survey (including Limited Mental Health) was conducted at the facility. During this survey, the facility did not have an admission discharge log containing the names and dates of admission and discharge for the mental health residents.	AL241		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340			
(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
AL241	Continued From page 5 On _____ at approximately 2:00 p.m, an interview was conducted with the Administrator and Manager. During this interview the Administrator and Manager confirmed that the facility did not have an up-to-date admission and discharge log for all mental health residents. The Manager reported that she will ensure that the facility has an up-to-date admission and discharge log for all mental health residents. class 3	AL241			
AZ815 SS=D	408.809, 435.02(2), 435.06 Background Screening; Prohibited Offenses 408.809, F.S. (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest who has been convicted of any such offense, the licensee shall submit to the agency a description and explanation of the conviction at the time of license application. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340			
(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
AZ815	Continued From page 6 responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's fingerprints to the Federal Bureau of Investigation for a national criminal history record check. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g), the person must file a complete set of fingerprints with the agency and the agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints may be retained by the Department of Law Enforcement under s. 943.05(2)(g). The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. Proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340		
(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
AZ815	Continued From page 7 professional licensure requirements of the agency, the Department of Health, the Agency for Persons with _____, the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 satisfies the requirements of this section if the person subject to screening has not been unemployed for more than 90 days and such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of chapter 435 and this section using forms provided by the agency. (3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340			
(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
AZ815	Continued From page 8 a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (g) Section 817.234, relating to false and fraudulent insurance claims. (h) Section 817.505, relating to patient brokering. (i) Section 817.568, relating to criminal use of personal identification information. (j) Section 817.60, relating to obtaining a credit card through fraudulent means. (k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (l) Section 831.01, relating to forgery. (m) Section 831.02, relating to uttering forged instruments. (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (p) Section 831.30, relating to fraud in obtaining medicinal drugs. (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. A person who serves as a controlling interest of, is employed by, or contracts with a licensee on , 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340		
(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
AZ815	Continued From page 9 31, 2015. The agency may adopt rules to establish a schedule to stagger the implementation of the required rescreening over the 5-year period, beginning _____, 2010, through _____, 2015. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: - Does not have an active professional license or certification from the Department of Health; or - Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340		
(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
AZ815	Continued From page 10 grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2). (8) There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06, F.S. (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity.	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340		
(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
AZ815	Continued From page 11 (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been _____ for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the _____ is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including fingerprints if required, must be disqualified for employment in such position or, if	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340		
(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
AZ815	Continued From page 12 employed, must be dismissed. (4) There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02(2), F.S. "Employee" means any person required by law to be screened pursuant to this chapter. This Statute or Rule is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that 3 of 3 sampled employees completed the Affidavit of Compliance with Background Screening Requirements. (Employees #1, #2 and #3) The Findings: On , a record review was conducted of Employees #1, #2 and #3 personnel files. Employee #1 was hired on / / , background screening was conducted on / / . There was no Affidavit of Compliance in the personnel file. Employee #2 started working at the facility on / / , background screening was approved on / / and there was no Affidavit of Compliance with Background screening in the personnel file. Employee #3 started working at the facility on / / , background screening was approved on / / and there was no Affidavit of Compliance with Background Screening Requirements.	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 MADISON, FL 32340		
(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
AZ815	Continued From page 13 On 1/ at approximately 2:00p.m, an interview was conducted with the Administrator and Manager. During this interview the Administrator and Manager confirmed that Employees #1, #2 and #3 did not have the Affidavit of Compliance with Background Screenings Requirements in their personnel files. The Administrator and Manager reported that they were not aware of the form and would ensure that all employees would have the form in their personnel files. class 3	AZ815		



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Meadowlands Senior Living
3533 Ne State Rd #6
Madison, FL 32340

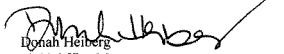
Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2012 by representative(s) of this office. Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after , 2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call me at 850-412-4540.

Sincerely,


Donah Heiberg
Field Office Manager

DH/dh
Enclosure

