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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 [redacted] the Biennial Relicensure survey was conducted for Meadowland Guest Home Assisted Living Facility (ALF). The ALF had deficiencies found at the time of the visit.	A 000		
A 008	58A-5.0181(2) FAC Admissions - Health Assessment (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a face-to-face medical examination completed by a licensed health care provider, as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days prior to the individual ' s admission to a facility pursuant to Section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations; 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living; 3. Any nursing or [redacted] services required by the individual; 4. Any special diet required by the individual; 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication; 6. Whether the individual has signs or symptoms of a communicable [redacted] which is likely to be transmitted to other residents or staff; 7. A statement on the day of the examination that, in the opinion of the examining licensed health care provider, the individual ' s needs can be met in an assisted living facility; and 8. The date of the examination, and the name, signature, address, phone number, and license	A 008		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 008	Continued From page 1	A 008		

number of the examining licensed health care provider. The medical examination may be conducted by a currently licensed health care provider from another state.
(b) A medical examination completed after the resident ' s admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, 2010. The form is hereby incorporated by reference. A faxed copy of the completed form is acceptable. A copy of AHCA Form 1823 may be obtained from the Agency Central Office or its website at www.fdhc.state.fl.us/MCHQ/Long_Term_Care/ <http://www.fdhc.state.fl.us/MCHQ/Long_Term_Care/> Assisted_living/pdf/AHCA_Form_1823%.pdf. The form must be completed as follows:
1. The resident ' s licensed health care provider must complete all of the required information in Sections 1, Health Assessment, and 2, Self-Care and General Oversight Assessment.
a. Items on the form that may have been omitted by the licensed health care provider during the examination do not necessarily require an additional face-to-face examination for completion.
b. The facility may obtain the omitted information either verbally or in writing from the licensed health care provider.
c. Omitted information received verbally must be documented in the resident ' s record, including the name of the licensed health care provider, the name of the facility staff recording the information and the date the information was provided.
2. The facility administrator, or designee, must complete Section 3 of the form, Services Offered or Arranged by the Facility, or may use electronic documentation, which at a minimum includes the

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 008	Continued From page 2	A 008		

elements in Section 3. This requirement does not apply for residents receiving:
a. Extended congregate care (ECC) services in facilities holding an ECC license;
b. Services under community living support plans in facilities holding limited mental health licenses;
c. Medicaid assistive care services; and
d. Medicaid waiver services.
(c) Any information required by paragraph (a) that is not contained in the medical examination report conducted prior to the individual ' s admission to the facility must be obtained by the administrator within 30 days after admission using AHCA Form 1823.
(d) Medical examinations of residents placed by the department, by the Department of Children and Family Services, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).
(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.426, F.S., and this rule.
(f) Any orders for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility issued by the licensed health care provider conducting the medical examination may be attached to the health assessment. A licensed health care provider may attach a _____ order for residents who do not wish _____ to be administered in the case of _____ or _____.
(g) A resident placed on a temporary emergency basis by the Department of Children and Family Services pursuant to Section 415.105 or

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 008	Continued From page 3 415.1051, F.S., shall be exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement shall be entered on the facility ' s admission and discharge log and counted in the facility census; a facility may not exceed its licensed capacity in order to accept a such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to obtain a Resident Health Assessment that was completed within 60 calendar days prior to admission or 30 days after admission for 2 of 4 sampled residents (#1 and #2). Findings: Review of the admission and discharge log revealed resident#1 was admitted into the facility on [redacted] and resident #2 was admitted on [redacted] Record review for resident #1 revealed a Resident Health Assessment Form (1823) that was dated [redacted] (more than 60 days old). Record review for resident #2 revealed an 1823 that was dated [redacted] (more than 60 days old). Further record review revealed that there was no 1823 form found in their records that were completed within 30 days after their admissions. The administrator confirmed the above findings. Class [redacted]	A 008		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 025	Continued From page 4	A 025		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain documentation of a report regarding a severe unplanned weight loss to the health care provider and family	A 025		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 025	Continued From page 5 members for 1 of 5 sampled residents (#2). Findings: Record review for resident #2 revealed a Resident Health Assessment form (1823) that was dated [redacted] with diagnosis that included [redacted] History of [redacted] and Generalized Muscular [redacted] Interview with the administrator revealed the resident required assistance with bathing, dressing and [redacted] Review of the weight records noted the following: [redacted] pounds lbs., [redacted] and [redacted] (day of the survey)-121 [redacted] From [redacted] through [redacted] the resident had lost 15 pounds which represents an 11.11% weight loss (severe) for a 1 month period. A patient progress note documented not eat meat only likes dessert and drink. Weight changed by looking at him?". Further observations revealed that there was no documentation to confirm that the facility staff had contacted the health care provider and family regarding the resident's severe weight loss. Observation of the resident during the survey revealed that he was frail and his clothing was loosely fitting. He was alert with [redacted] During lunch he did eat most of the meal that was served to him. The administrator stated that she was aware of the resident's weight loss and had reported it the health care provider and he did not give her any instructions.	A 025		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 025	Continued From page 6 Class III	A 025		
A 032	58A-5.0182(8) FAC Resident Care - Elopement Standards (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision. 1. As part of its resident elopement response policies and procedures, the facility shall 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 attention shall be directed towards residents assessed at high risk for elopement, with special attention given to those with [redacted] and related [redacted] assessed at high risk. 2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident ' s family/caregiver. (b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall	A 032		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 032	Continued From page 7 include: 1. An immediate staff 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 shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a resident with at risk of elopement had identification on his person that included his name, the facility's name, address and telephone number for 1 of 5 sampled residents (#2). Findings: The administrator stated on [redacted] approximately 10 AM that resident #2 was up all night and the early morning wandering around the facility. She stated that early in the morning (no time given-day of survey) the resident was found in the field that was located on the property of facility and was across the parking lot. The resident was wandering around there looking for his wife that had passed [redacted] ago. She explained that she was in the kitchen the some of the residents who were outside smoking	A 032		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 032	Continued From page 8	A 032		

observed him in the field and informed her that he was there.

An interview was attempted with resident #2 and he could not appropriately answer the questions asked of him, he was pleasantly

During the survey the resident was observed walking around the facility. Observation at approximately 11:45 AM revealed the resident opened the door and went outside, there were other residents outside, who yelled into the facility, to the administrator (who was in the kitchen) that resident#2 was outside. The administrator went outside and was heard persuading resident #2 to return inside of the facility.

Interviews with several residents revealed that resident #2 was confused, [redacted] always up during the night and early morning wandering around, opening the refrigerator trying to leave looking for his wife, the resident's interviewed all knew his deceased [redacted] e's name, because when he started wandering he would tell them he was looking for his wife and he would mention her name during his search.

The administrator confirmed that he was exit seeking and was searching for his wife. The facility was not a locked unit and the resident would be able to leave at any time someone was not watching him. The administrator further stated that the resident was an elopement risk and had no identification on his person that included his name, the facility's name, address and telephone number.

Class III

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 9	A 054		
A 054	58A-5.0185(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed under subsection (2), the facility shall 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 shall maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications or medication administration. A MOR must include the name of the resident and any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number; the name, strength, and directions for use of each medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered. (c) For medications which serve as chemical , the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician ' s annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on Record review and interview the facility failed to maintain an accurate Medication Observations Records (MOR) for 3 of 5 sampled residents (#1, #2 and #4). Findings:	A 054		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 10	A 054		

Review of the Medication Observations Record (MOR) for resident #1, #2 and #4 revealed that staff had a circle in some of the spaces on the MOR and there was no explanation on the back that indicated what the circle meant to determine whether or not the residents received their medications.

1. Resident #1 MOR 2012 noted:
one daily at 9 AM had circles in the spaces on the 17th through the 20th
one daily at 9 AM had circles in the spaces on the 17th through the 19th
Ferrex one daily at 9 AM had circles in the spaces on the 17th through the 23rd
one daily at 9 AM had circles in the spaces on the 17th through the 19th
3 times daily had circles in the spaces at 8 AM, 2 PM and 8 PM on the 24th through the 29th.
1 at bedtime (8 PM) had circles on the spaces on the 17th through the 20th
Further review of the MOR revealed that spaces were left blank from the 28th through the 30th for the following medications:
20 mg 1 at bedtime
500 mg 1 at bedtime
50 mg one at bed time

2. Resident #2 MOR 2012 noted:
HC I twice daily at 8 PM had a circle in the spaces on the 4th

3. Resident #4 MOR 2012 noted:
one daily at 8 AM had circles in the spaces on the 4th and the 5th, 17th through 19th.
Syst at 8 AM had circles in the spaces on the 2nd through the 4th, 9th

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 11 through the 12th, 18th through the 20th and the 24th through the 26th at 8 AM had circles in the spaces on the 2nd through the 4th, 10th through the 12th and the 24th through the 26th 500 mg 1 twice daily At 8 AM had a circles in the spaces on the 3rd through the 5th, 9th through the 12th, 18th through the 20th, 26th through the 28th. AT 8PM on the 2nd and the 3rd, 10th through the 12th, 17th through the 20th, 26th through the 28th. 10 mg one daily at 8 AM had a circles in the spaces on the 2nd and the 3rd, 10th through the 12th, the 14th, 17th through the 19th, 24th through the 26th. MOR 2012 noted: 25 mg 1 twice daily at 8 AM and 8PM had circles in the spaces on the 1st through the 3rd Syst at 8 AM had circles in the spaces on the on the 1st through the 3rd at 8 AM had circles in the spaces on the 1st through the 3rd 500 mg 1 twice daily at 8 AM and 8 PM on the 1st through the 3rd. Interview with the administrator at approximately 1 PM stated the circles were made by staff B and she did not know what the circles meant nor did she know why the spaces on the MOR were left blank. Class III	A 054		
A 076	58A-5.0186 FAC	A 076		

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
	AL11922356	A. BUILDING ______ B. WING ______	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 076	Continued From page 12	A 076		

(1) POLICIES AND PROCEDURES.
(a) Each assisted living facility (ALF) must have written policies and procedures, which delineate its position with respect to state laws and rules relative to _ . . . . . . The policies and procedures shall not condition treatment or admission upon whether or not the individual has executed or waived a . The ALF must provide the following to each resident, or resident ' s representative, at the time of admission:
1. A copy of Form SCHS-4-2006, " Health Care Advance Directives - The Patient ' s Right to Decide, " 2006, or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in Chapter 765, F.S. Form SCHS-4-2006 is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308, or the agency ' s Web site at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and
2. Written information concerning the ALF ' s policies regarding ; and
3. Information about how to obtain DH Form 1896, Florida Form, incorporated by reference in Rule 64J-2.018, F.A.C.
(b) There must be documentation in the resident ' s record indicating whether or not he or she has executed a _ . . . . . If a . . . . . has been executed, a copy of that document must be made a part of the resident ' s record. If the ALF does not receive a copy of a resident ' s executed , the ALF must document in the resident ' s record that it has requested a copy.
(2) LICENSE REVOCATION. An ALF shall be subject to revocation of its license pursuant to Section 408.815, F.S., if, as a condition of

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 076	Continued From page 13 treatment or admission, it requires an individual to execute or waive a _____. (3) _____ PROCEDURES. Pursuant to Section 429.255, F.S., an ALF must honor a properly executed _____ as follows: (a) In the event a resident experiences _____, staff trained in _____, or a licensed health care provider present in the facility, may withhold _____. (b) In the event a resident is receiving hospice services and experiences _____, facility staff must immediately contact the hospice. The hospice procedures shall take precedence over those of the assisted living facility. (4) LIABILITY. Pursuant to Section 429.255, F.S., ALF providers shall not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for following the procedures set forth in subsection (3) of this rule, which involves withholding or withdrawing _____ pursuant to a _____ and rules adopted by the department. This Statute or Rule is not met as evidenced by: Based facility record review, record review and interview the facility failed to have accurate written policies and procedures, which delineate its position with respect to state laws and rules relative to _____. Findings:	A 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 076	Continued From page 14	A 076		

Review of the Facility's ..... policy and procedure on ..... at approximately 11:30 AM revealed the policy did not included the required documentation to be given to the resident's or their representative at the time of admission. The Policy and Procedure did not include the following:

A ..... policy that indicated that Pursuant to Section 429.255, F.S., an ALF must honor a properly executed ..... as follows: (a) In the event a resident experiences ..... staff trained in ..... or a licensed health care provider present in the facility, may withhold ..... (b) In the event a resident is receiving hospice services and experiences ..... facility staff must immediately contact the hospice. The hospice procedures shall take precedence over those of the assisted living facility.

A policy that included all items listed below was not available for review.

1. At the time of admission, provide each resident, or the resident's representative, with a copy of Form SCHS-4-2006, "Health Care Advance Directives - The Patient's Right to Decide," effective ..... 2006, or with a copy of some other substantially similar document which incorporates information regarding advance directives included in Chapter 765, F.S.

2. At the time of admission, provide each resident, or the resident's representative, with written information concerning the facility's policies regarding ..... and advance directives, including information concerning DH Form 1896, Florida .....

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
	AL11922356	A. BUILDING _____ B. WING _____	12/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 076	Continued From page 15 Form, incorporated by reference in Rule 64 E-2.031, F.A.C. 3. At the time of admission, provide each resident, or the resident's representative, with written information concerning the facility's policies respecting advance directives. 4. The requirement that documentation of whether or not the resident had executed an advance directive must be contained in the resident's record. If an advanced directive has been executed, a copy of that document must be made a part of the resident's record. If the facility did not receive a copy of the advanced directive for a resident, the facility must document in the resident's record that it requested a copy. Record review for Residents #1, #2 revealed that there was no documentation to confirm that they had received the above information. The administrator confirmed the above findings. Class III	A 076		
A 078	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable [illegible] including [illegible] Freedom from [illegible] must be documented on an annual basis. A person with a positive [illegible] test must submit a health care provider ' s statement that the person does not constitute a risk of	A 078		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 078	Continued From page 16	A 078		

communicating tuberculosis. hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable disease, she shall be removed from duties until the administrator determines that such condition no longer exists.

(b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter.

(c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C.

(d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents.

(e) For facilities with a licensed capacity of 17 or more residents, the facility shall:

1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and

2. Maintain time sheets for all staff.

This Statute or Rule is not met as evidenced by:
Based on Personal record review and interview

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 078	Continued From page 17 the facility failed to ensure that 1 staff in a sample of 2 staff (A) who was a newly hired staff had a statement from a health care provider that was based on an examination that was conducted within the last six months, that she did not have any signs or symptoms of a communicable ... including ... and 1 of 2 staff (B) had an annual statement from her health care provider documenting freedom from ... Findings: Staff A (The administrator) stated on ... at approximately 9:30 AM that she was hired in 5/2012. Personnel record review for staff A revealed that she had no documentation in her file to confirm that she was free from signs or symptoms of a communicable ... Further personnel record review revealed that her freedom from ... statement was dated ... Personnel record review for staff B hired in ... revealed that her freedom from ... statement was dated ... Staff A confirmed the above findings. Class III	A 078		
A 081	58A-5.0191(2) FAC Training - Staff In-Service (2) 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 ...	A 081		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 081	Continued From page 18	A 081		

control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [redacted] borne [redacted], 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 major incidents.
2. Reporting adverse incidents.
3. 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

(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

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 081	Continued From page 19 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 personnel record review and interview the facility failed to ensure that 1 of 2 sampled staff (A) received in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment. Findings: Personnel record review on [redacted] at approximately 1 PM, revealed that staff A, was hired in [redacted] and there was no documentation to confirm that she had received in-service training regarding the facility's resident elopement response policies and procedures within 30 days of employment. Staff A (The administrator) stated at the time she had not received the training as required. Class III	A 081		
A 083	58A-5.0191(4) FAC Training - First Aid and [redacted] (4) FIRST AID AND [redacted] A staff member who has completed courses in First Aid and [redacted] and	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 083	Continued From page 20 holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation of attendance at First Aid or course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to ensure that 1 of 2 sampled staff members (A) who worked alone, held currently valid card documenting completion of courses in First Aid and Findings: Review of the staff schedule on at approximately 10:30 AM revealed that staff A worked at the facility alone and she was working alone at the facility the day of the survey. Personnel Record review revealed that staff A (the administrator) had a First Aid and card that both expired in Staff A confirmed that her and First Aid had expired.	A 083		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 083	Continued From page 21 Class III	A 083		
A 084	58A-5.0191(5) FAC Training - Assis Self-Admin Meds & Med Mgmt (5) ASSISTANCE WITH SELF-ADMINISTERED MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with self-administered medications as described in Rule 58A-5.0185, F.A.C., must meet the training requirements pursuant to Section 429.52(5), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques and provide opportunities for hands-on learning through practice exercises. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates an ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with Section 429.256, F.S., and Rule	A 084		

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
	AL11922356	A. BUILDING _____ B. WING _____	12/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 084	Continued From page 22	A 084		

58A-5.0185, F.A.C., including:
a. Assist with oral dosage forms, dosage forms, and and nasal dosage forms;
b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions;
c. Recognize the need to obtain clarification of an " as needed " prescription order;
d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident ' s health care provider or facility employer of inability to assist in the administration of such orders;
e. Complete a medication observation record;
f. Retrieve and store medication; and
g. Recognize the general signs of adverse reactions to medications and report such reactions.
(c) Unlicensed persons, as defined in Section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 4 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training shall only be provided by a licensed registered nurse, or a licensed pharmacist.

This Statute or Rule is not met as evidenced by:
Based on personnel record review and interview the facility failed to ensure that 2 of 2 sampled unlicensed staff (A and B), who provided assistance with the resident's medications received 2 hours in-service training each year in providing assistance with self-administered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 084	Continued From page 23 medications and safe medication practices in an Assisted Living Facility (ALF). Findings: Staff A (The administrator) stated on _____ at approximately 11 AM that she and Staff B assisted with the self-administration of the resident's medication. Personnel record review for staff A revealed she had received the 4 hour training _____ and Staff B had received the 4 hour training on _____ and there was no documentation to confirm that they had received the 2 hours in-service training each year. The administrator stated at the time she and staff B had not received a 2 hours medication training yearly as required. Class III	A 084		
A 090	58A-5.0191(11) FAC Training - Do Not Orders (11) _____ TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policies and procedures regarding _____ within 60 days after the effective date of this rule. (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility ' s policy and procedures regarding _____ within 30 days after employment.	A 090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 090	Continued From page 24 (c) Training shall consist of the information included in Rule 58A-5.0186, F.A.C. This Statute or Rule is not met as evidenced by: Based on Personnel record review and interview the facility failed to ensure that 1 of 2 sampled staff (A) had at least one hour of training in the facility's policies and procedures regarding : that included information in Rule 58A-5.0186, F.A.C. Findings: Personnel record review on : at approximately 1 PM, revealed that staff A, was hired in : and there was no documentation to confirm she had obtained at least one hour of training on the facility's policies and procedures regarding : that included information in Rule 58A-5.0186, F.A.C. Staff A (The administrator) confirmed that she had not obtained the above training. Class III	A 090		
A 092	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 092	Continued From page 25 manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on facility record review and interview the facility who provided food service, failed to ensure that there was a person designated in writing to be responsible for total food services and the day to day supervision of food services staff. Findings: Review of the facility's documentation revealed that there was no documentation found to determine who was responsible for total food services and the day to day supervision of food services staff. The administrator was asked at approximately 1:30 PM who was responsible for total food services and the day to day supervision of food services staff and she did not know. She further stated that there was no documentation from the owner to confirm that she had designated a staff that would responsible for total food services and the day to day supervision of food services staff. Class III	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	**6767 ROUND LAKE ROAD MOUNT DORA, FL 32757**

(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 093	Continued From page 26	A 093		
A 093	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council, adjusted for age, [illegible] and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet.	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 093	Continued From page 27 Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care provider ' s order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility. 2. The facility shall document a resident ' s refusal to comply with a therapeutic diet and notification to the resident ' s health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident ' s responsible party refusing the diet is acceptable documentation of a resident ' s preferences. In such instances daily documentation is not necessary.	A 093		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 093	Continued From page 28	A 093		

(f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals.
(g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand.
(h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority.

This Statute or Rule is not met as evidenced by:
Based on observations, menu review and

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 093	Continued From page 29	A 093		

interview the facility failed to ensure menus to be served were planned at least one week in advance for both regular and therapeutic diets and for the menus that were to be served and to have substitutions with items of comparable nutritional value, were not reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, and did not maintain a 3-day emergency supply of non-perishable foods on hand at all times that included vegetables, non-perishable milk and water to meet the nutritional needs of 5 resident, based on the Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition Board - National Research Council in the event of an emergency.

Findings:

1. Review of the menu used by the facility revealed that the last time that it was reviewed by the registered Dietitian was .....

2. Observations during lunch at approximately 12:30 PM revealed that the residents were served Spaghetti with meat sauce, broccoli and a slice of bread and jello.

The menu noted that Swedish meat ball with gravy, mixed vegetables, toss salad with dressing a roll with margarine and lemon pie was to be served. The staff member scratched out the Swedish meat ball and noted spaghetti on the menu.
When the administrator was asked why there were substitutions, she stated that the resident's liked the spaghetti; there were no mixed vegetables, no toss salad and no lemon pie to be served at the facility. She stated that only one of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 093	Continued From page 30	A 093		

the resident's like tossed salad and the owner did not purchase salad for that reason.
There was no substitution served for the toss salad.

3. None of the other foods that were substituted were noted on the menu.

4. Review of the menu to be served for the remainder of the week revealed that some of the food to be served was not available at the facility.
For Dinner on 12/4 (day of the survey)-Coleslaw and fresh fruit was to be served and there was none at the facility.
Lunch on 12/5-Banana pudding, Toss salad and Ginger bread was to be served and there was none at the facility.
Lunch on 12/6-Toss Salad was to be served and there was none
Dinner on 12/6-Cottage cheese and pears was to be served and there was none
12/7-Lunch-Fruit Cocktail and topping was to be served and there was none
12/7-Dinner- Beets, coleslaw and Peanut butter cake was to be served and there was none
12/8-Lunch-Stuffing, Toss salad and mixed vegetables was to be served and there was none
12/8/-Dinner-Meat loaf, Citrus Sections was to be served and there was none

5. Observations of the emergency food supply revealed that there were no non-perishable vegetables available.
There were only 12 servings of evaporated milk and 30 serving were needs-(2 servings per day x 3 days x 5 residents). There was only 5 gallons of water and 15 were required (1 gallon per day for 3 days x 5 residents).

The administrator confirmed the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 093	Continued From page 31	A 093		
	Class III			
A 167	58A-5.025(1) FAC Resident Contracts	A 167		

Resident Contracts.
(1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions:
(a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services.
(b) The daily, weekly, or monthly rate.
(c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract.
(d) A provision giving at least 30 days written notice prior to any rate increase.
(e) Any rights, duties, or of residents, other than those specified in Section 429.28, F.S.
(f) The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments.
(g) A refund policy which shall conform to Section 429.24(3), F.S.
(h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 167	Continued From page 32	A 167		

facility unless the resident ' s medical condition, such as the resident ' s being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident ' s behalf.
(i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility.
(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident ' s representative, or agency acting on the resident ' s behalf, shall be notified in writing that the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect.
(k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule.
(l) The facility ' s policies and procedures for self-administration, assistance with self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule.
(m) The facility ' s policies and procedures related to a properly executed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 167	Continued From page 33	A 167		

This Statute or Rule is not met as evidenced by:
Based on record review and resident contract review and interview the facility failed to ensure that 2 of 2 sampled residents received a contract that contained the rights, duties and of residents, other than those specified in the Resident Bill of Rights

Findings:

Record review, including contract review for resident #1 and #2 revealed the following information was not included as required:

There was no list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services.

A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract.

1. There is a provision giving at least 30 days written notice prior to any rate increase.
2. Any rights, duties, or of residents, other than those specified in Section 429.28, F.S.
3. The purpose of any advance payments or deposit payments and the refund policy for such advance or deposit payments.
4. A refund policy which shall conform to Section 429.24(3), F.S.
5. A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 167	Continued From page 34 A provision that upon determination by the administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident's representative, or agency acting on the resident's behalf, shall be notified in writing that the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect. A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years thereafter, or after a significant change, pursuant to subsection (4) of that rule. The administrator provided a copy of the contract used by the facility that had some of the above documentation, she explained that she had no documentation; to confirm that the resident was given a copy. Class	A 167		
AZ815	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:	AZ815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 35	AZ815		

(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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 36	AZ815		

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 37	AZ815		

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 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 38	AZ815		

(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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 39	AZ815		

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:
1. Does not have an active professional license or certification from the Department of Health; or
2. 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 40	AZ815		

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.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 41 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 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 the record review and interview the facility failed to comply with the attestation requirements of section 435.05(2), Florida	AZ815		

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
	AL11922356	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWLAND GUEST HOME	6767 ROUND LAKE ROAD MOUNT DORA, FL 32757

(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 42 Statutes, which state that every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if [redacted] for any of the disqualifying offenses while employed by the employer for 2 of 2 sampled staff (A and B). Findings: Personnel record review on [redacted] at approximately 1 PM for Staff A and B revealed that there was no documentation to confirm that employees who were required to undergo Level 2 background screening had completed any type of affidavit or documentation attesting, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if [redacted] for any of the disqualifying offenses while employed by the employer per 435.05(2), Florida Statutes. The Staff A the administrator confirmed the findings. Class . .	AZ815		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Meadowland Guest Home
6767 Round Lake Road
Mount Dora, FL 32757

Dear Administrator:

Re: Biennial relicensure

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 Lorraine Henry at .

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone (407) 420-2502; Fax (407) 245-0998