STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910382	02/15/2016
NAME OF PROVIDER OR SUPPLIER **ATRIA MERIDIAN**	STREET ADDRESS, CITY, STATE, ZIP CODE **3061 DONNELLY DRIVE** **LANTANA, FL 33462**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced licensure complaint investigation, CCR 2015012249, was conducted on 02/15/16 at Atria Meridian. The facility had a deficiency identified at the time of the investigation.

Z815 Background Screening: Prohibited Offenses

Based on record review and interviews, the facility failed to conduct a new Level 2 background screening , for 1 of 3 sampled employee records reviewed (Employee B). This had the potential to affect all residents who received care from Employee B.

The findings included:

Review of employee records was conducted / with the Administrator and Community Business Director (in charge of human resources) present. Review of the employee record for Employee B, a Resident Service Aide (caregiver), revealed a date of hire as .

Further review of Employee B's record revealed no documentation showing a Level 2 background screening was conducted for this employee. The Community Business Director accessed the Agency background screening database and discovered Employee B's status was reflected as "New screening required", there was no Level 2 background screen eligibility status for this employee. This was discussed with and acknowledged by the Administrator and Community Business Director on / at 4:17 PM.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Atria Meridian
3061 Donnelly Drive
Lantana, FL 33462

RE: CCR #2015012249

Dear Administrator:

This letter reports the findings of a state compliant licensure survey that was conducted on , 2016 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

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