

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLE VISTA BLUFFS

**1138 ROSEMARY DRIVE
LARGO, FL 33770**

(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 A biennial re-licensure survey was conducted at Belle Vista Bluffs ALF on The provider had deficiencies at the time of the visit.	A 000		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of	A 078		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER BELLE VISTA BLUFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 1138 ROSEMARY DRIVE LARGO, FL 33770		
(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 1 education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must 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 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 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. (f) Level 2 background screening must be conducted for staff, including staff _____ by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of a negative _____ () exam and a health care provider's statement that a staff member was free of all communicable _____ within 30 days after beginning employment for 1 of 3 staff (Staff B), whose records were reviewed.	A 078			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER BELLE VISTA BLUFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 1138 ROSEMARY DRIVE LARGO, FL 33770		
(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)	
A 078	Continued From page 2 Findings included: A record review of Staff B's employment records was conducted on The records showed that Staff B began employment on Staff B's records did not contain any evidence of a negative . . screening or a statement from a healthcare provider that he was free of all communicable An interview with the Administrator was conducted at 2:30pm on and she stated she thought that the documents were in the record, but upon learning they were not, was not sure why and would have to look into it. Class III		A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011(. . .) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in in-service training relevant to their job duties as specified by agency rule of the agency. Topics covered during		A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER BELLE VISTA BLUFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 1138 ROSEMARY DRIVE LARGO, FL 33770		
(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 3 the preservice orientation are not required to be repeated during in-service training. A single certificate of completion that covers all required in-service training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLE VISTA BLUFFS

**1138 ROSEMARY DRIVE
LARGO, FL 33770**

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

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER BELLE VISTA BLUFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 1138 ROSEMARY DRIVE LARGO, FL 33770		
(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 5 regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 of 3 staff members, whose records were reviewed (Staff B), had received all of the required in-service training within the first 30 days of employment. Findings included: A records review conducted on _____ revealed that Staff B began employment on _____. The record did not contain any evidence that Staff B had a 3 hour training course on resident activities of daily living (ADLS) and behavioral needs and a training course on the facility's emergency procedures. In an interview with the Administrator at 2:30pm on _____, she stated she thought that the training had occurred and could not explain why the training certificates were not in the record. Class III	A 081			
A 087 SS=D	58A-5.0194 FAC _____ Training - Prov & Curriculum Appr	A 087			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLE VISTA BLUFFS

**1138 ROSEMARY DRIVE
LARGO, FL 33770**

(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 087	Continued From page 6 (1) The _____ or Related ("ADRD") training provider and curriculum must be approved by the department or its designee before commencing training activities. The department or its designee will maintain a list of approved ADRD training providers and curricula, which may be obtained from http://usfweb3.usf.edu/trainingonAging/default.aspx . (a) ADRD Training Providers. 1. Individuals who seek to become an ADRD training provider must provide the department or its designee with the documentation of the following educational, teaching, or practical experience: a. A Master's degree from an accredited college or university in a health care, human service, or _____ related field; or b. A Bachelor's degree from an accredited college or university, or licensure as a registered nurse, and: (i) Proof of 1 year of teaching experience as an educator of caregivers for individuals with _____ or related _____; or (ii) Proof of completion of a specialized training program specifically relating to _____'s _____ or related _____, and a minimum of 2 years of practical experience in a program providing direct care to individuals with _____ or related _____; or (iii) Proof of 3 years of practical experience in a program providing direct care to persons with _____ or related _____. c. Teaching experience pertaining to _____'s _____ or related _____ may substitute on a year-by-year basis for the required Bachelor's degree. 2. Applicants seeking approval as ADRD training providers must complete DOE form	A 087		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER BELLE VISTA BLUFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 1138 ROSEMARY DRIVE LARGO, FL 33770		
(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 087	Continued From page 7 ALF/ADRD-001, Application for _____'s or Related _____ Training Provider Certification, dated _____, which is incorporated by reference and available at the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000 and online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04000 . (b) ADRD Training Curricula. Applicants seeking approval of ADRD curricula must complete DOE form ALF/ADRD-002, Application for _____'s or Related _____ Training Three-Year Curriculum Certification, dated _____, which is incorporated by reference and available at the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000 and online at http://www.flrules.org/Gateway/reference.asp?No=Ref-04001 . Approval of the curriculum will be granted based on how well the curriculum addresses the subject areas referenced in subparagraphs 58A-5.0191(4)(a)2. and 58A-5.0191(4)(a)5., F.A.C. Curriculum approval will be granted for 3 years. After 3 years the curriculum must be resubmitted to the department or its designee for approval. (2) Approved ADRD training providers must maintain records of each course taught for a period of 3 years following each training presentation. Course records must include the title of the approved ADRD training curriculum, the curriculum approval number, the number of hours of training, the training provider's name and approval number, the date and location of the course, and a roster of trainees. (3) Upon successful completion of training, the trainee must be issued a certificate by the approved training provider. The certificate must	A 087			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLE VISTA BLUFFS

**1138 ROSEMARY DRIVE
LARGO, FL 33770**

(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 087	Continued From page 8 include the trainee's name, the title of the approved ADRD training, the curriculum approval number, the number of hours of training received, the date and location of the course, the training provider's name and approval number, and dated signature. (4) The department or its designee reserves the right to attend and monitor ADRD training courses, review records and course materials approved pursuant to this rule, and revoke approval for the following reasons: non-adherence to approved curriculum, failing to maintain required training credentials, or knowingly disseminating any false or misleading information. (5) ADRD training providers satisfying the requirements of Section 400.1755, F.S., relating to nursing homes, and Section 400.6045, F.S., relating to hospices, will satisfy the Level 1 and Level 2 training provider requirements of subparagraph 58A-5.0191(4)(a)3. and paragraph 58A-5.0191(4)(a), subsection (5), F.A.C. ADRD training curricula satisfying the requirements of Section 400.1755, F.S., relating to nursing homes, and Section 400.6045, F.S., relating to hospices, will satisfy the Level 1 curriculum requirements of subparagraph 58A-5.0191(4)(a)3., F.A.C. This Statute or Rule is not met as evidenced by: Based on records reviews and interview, the facility failed to provide evidence that staff members received the required training for working with residents with _____'s _____ and related _____ (ADRD) for 3 of 3 staff members (Staff A, Staff B and Staff C) whose records were reviewed. Findings Included:	A 087		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLE VISTA BLUFFS

**1138 ROSEMARY DRIVE
LARGO, FL 33770**

(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 087	Continued From page 9 A review of the facility's history and profile on AHCA's Florida Health Finders website was conducted on . The facility's profile stated that they provided memory care. A review of Staff A's record was conducted on . The record revealed there was some evidence of ADRD training, however it was not the required 4 hour ADRD Level I (due within 3 months of beginning employment) or the required ADRD Level II (due within 9 months of employment) training. Staff A's records indicated that he began employment on , and had worked in the facility almost 2 years. A review of Staff B's record was conducted on . Staff B began employment on and had worked in the facility for over 5 months. Staff B's record did not contain any evidence of having taken the 4 hour ADRD Level I training course. A review of Staff C's record was conducted on . The record revealed that Staff C began employment on and had been working in the facility for over 1 year. The record did not contain any evidence that Staff C has taken either the 4 hour ADRD Level I or the ADRD Level II courses that were required. In an interview with the Administrator at 2:30pm on , the Administrator did not seem to realize that the 4 hour ADRD Level I and Level II courses were required if a facility advertised that it provided memory care services. Class II	A 087		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER BELLE VISTA BLUFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 1138 ROSEMARY DRIVE LARGO, FL 33770		
(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 A 093 SS=D	Continued From page 10 59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003 , and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%202014.pdf . Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through 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 facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the	A 093 A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER BELLE VISTA BLUFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 1138 ROSEMARY DRIVE LARGO, FL 33770		
(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 11 facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. 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 must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must 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 that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/17/2020
NAME OF PROVIDER OR SUPPLIER BELLE VISTA BLUFFS			STREET ADDRESS, CITY, STATE, ZIP CODE 1138 ROSEMARY DRIVE LARGO, FL 33770		
(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 12 food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must 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, must be on (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must 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 and interviews, the facility failed to maintain a 3-day food supply of nonperishable food on at all times, based on 3 meals per day for 7 of 7 residents. A tour of the facility's emergency food storage area was conducted at 12:45pm on At the time of the tour, the Administrator pointed to nearly empty shelves with some nonperishable foods including Tang orange flavored powder, 2 boxes of Cheerios cereal and 1 box of Instant	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922155	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/17/2020
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BELLE VISTA BLUFFS

**1138 ROSEMARY DRIVE
LARGO, FL 33770**

(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 13 Breakfast, 1 box of instant mashed potatoes, a few cans of peaches, about 12 small cans of vegetables (peas, corn and potatoes), 1 small can of spam, 6 small cans of tuna fish, 1 large jar of peanut butter and a few boxes of freeze dried instant soup. There was no bottled water in the emergency storage to _____ the soup, mashed potatoes, instant breakfast or Tang. There was no bread or crackers to serve with the peanut butter. There was no canned or powdered milk to serve with the cereal. The facility had a census of 7 residents, therefore would be required to maintain 21 nutritious meals on _____ in case of emergency. There did not appear to be enough food in the non-perishable pantry to feed the 7 residents, should an emergency occur where they would need to rely on non-perishable items. The Administrator stated, at the time of the tour at 12:45pm on _____, that she thought since they had a generator that would run the refrigerator and cooking appliances, they did not really need to have that much nonperishable food. Class III	A 093		