

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969310</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/21/2021</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**WATERMARK AT VISTAWILLA, THE**

**1519 EAST SR 434  
WINTER SPRINGS, FL 32708**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>A complaint investigation #2021008427 and an<br>control monitoring were both conducted<br>at The Watermark at Vistawilla on . The<br>facility had a deficiency at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | A 000               |                                                                                                                          |                          |
| A 093<br>SS=D            | 59A-36.012(2) FAC Food Service - Dietary<br>Standards<br><br>(2) DIETARY STANDARDS.<br>(a) The meals provided by the assisted living<br>facility must be planned based on the current<br>USDA Dietary Guidelines for Americans, 2010,<br>which are incorporated by reference and<br>available for review at:<br><a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04003">http://www.flrules.org/Gateway/reference.asp?No=Ref-04003</a> , and the current summary of Dietary<br>Reference Intakes established by the Food and<br>Nutrition Board of the Institute of Medicine of the<br>National Academies, 2010, which are<br>incorporated by reference and available for<br>review at:<br><a href="http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%202014.pdf">http://iom.edu/Activities/Nutrition/SummaryDRIs/~media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%202014.pdf</a> . Therapeutic diets must meet these<br>nutritional standards to the extent possible.<br>(b) The residents' nutritional needs must be met<br>by offering a variety of meals adapted to the food<br>habits, preferences, and physical abilities of the<br>residents, and must be prepared through the use<br>of standardized recipes. For facilities with a<br>licensed capacity of 16 or fewer residents,<br>standardized recipes are not required. Unless a<br>resident chooses to eat less, the facility must<br>serve the standard minimum portions of food<br>according to the Dietary Reference Intakes.<br>(c) All regular and therapeutic menus to be used<br>by the facility must be reviewed annually by a<br>licensed or registered dietitian, a licensed | A 093               |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969310</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/21/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WATERMARK AT VISTAWILLA, THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1519 EAST SR 434<br/>WINTER SPRINGS, FL 32708</b>                            |                          |                                                        |
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| A 093                                                                   | <p>Continued From page 1</p> <p>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 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.</p> <p>1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.</p> <p>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.</p> <p>(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.</p> <p>(e) Therapeutic diets must be prepared and served as ordered by the health care provider.</p> <p>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.</p> <p>2. The facility must document a resident's refusal to comply with a therapeutic diet and provide</p> | A 093                                                                          |                                                                                                                          |                          |                                                        |

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| A 093                                                                   | <p>Continued From page 2</p> <p>notification to the resident's health care provider of such refusal.</p> <p>(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 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.</p> <p>(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 _____.</p> <p>(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.</p> <p>This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to keep regular and therapeutic menus on file in the facility for 6 months.</p> <p>Findings:</p> | A 093                                                                                         |                                                                                                                          |                                                        |

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| A 093                    | <p>Continued From page 3</p> <p>Review of the dated menus that were provided by the dietary manager revealed they were dated from ..... through ..... . A request was made to review the last 6 months of menus.</p> <p>At 1:30 p.m. on ..... the administrator said additional dated menus could not be located.</p> <p>Class III</p> | A 093               |                                                                                                                          |                          |