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
	AL11953622	A. BUILDING: _____ B. WING _____	06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE POINTE	9797 BAY PINES BLVD SAINT PETERSBURG, FL 33708

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A 000	Initial Comments A complaint survey (complaint #2024007772) was conducted at The Pointe on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 025	Continued From page 1 59A-36.012, 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 resident. (c) Maintaining a 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. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that 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 provide personal supervision as appropriate to each resident, for 5 of 5 residents (#2, #3, #4, #5 and #6) living in the memory care unit. In addition, the facility failed to notify residents' families, or physicians, of a change in condition ( ) for 3 of 3 memory care residents (#3, #5 and #6), whose records were reviewed. Findings Included: An interview was conducted with Staff B at 11:05am on , she stated that there were	A 025		

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A 025	Continued From page 2	A 025		

times when there was not enough staff to meet the needs of the residents, , , on nights and weekends when staff called off from work or when staff just did not show up or work. She stated that not everyone was on the same page when it came to helping residents. In the memory care unit they had residents that needed toileting checks every 2 hours. The staff were supposed to document that they saw the residents every 2 hours, on a safety checks log.

A review of the memory care 2 hour safety checks log, which covered the 2 hour toileting checks, was conducted on . The record showed that on , the memory care staff checked off for only 2 safety checks the entire 24 hour period (7:00am and 9:00am), for all 5 residents living on the unit, and the log was not signed off by any of the care staff. The record showed that on , the memory care staff checked off for only 5 safety checks the entire 24 hour period (7:00am, 9:00am, 11:00am, 1:00pm and 3:00pm). The record showed that on (at 12:05pm on) there were no safety checks signed off at all for the entire day, since it began at 7:00am.

A review of the staffing schedule on revealed that there were no care staff scheduled on the memory care unit for for the 11:00pm - 7:00am shift and on on for the 3:00pm - 11:00pm shift. There were no staff scheduled on the memory care unit for and on the 11:00pm - 7:00am shift, and no staff scheduled on the memory care unit for on the 7:00am - 3:00pm shift.

A review of Resident #3's record on

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A 025	Continued From page 3 revealed that she had a risk assessment on and scored an 11 on the assessment, with a score of 10 or more indicting a high risk for . The record showed that Resident #3 had recorded incident on . The resident was reportedly sent to the local hospital and treated for a on her left and diagnostic were performed. The record showed no documentation that the facility had notified the resident's family or physician. A review of Resident #5's record on revealed that she had a recorded incident on , when she in the dining room and bumped the of her . The facility sent her out to the hospital. The record showed no documentation that the facility had notified the resident's family or physician. A review of Resident #6's record on revealed that he had recorded incidents on and . On , he was found in his apartment, on the floor beside a chair, after an unwitnessed . The record showed no documentation that the facility had notified the resident's family or physician. On , he was found sitting on grassy area outside the facility after he slipped and could not get up. The record showed no documentation that the facility had notified the resident's family or physician. In an interview with the Nursing Director at 4:50pm on , when it was discussed that incidents had not been documented that they were reported to the family or the resident's physician, she stated that the care staff wrote the incident reports.	A 025		

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A 025	Continued From page 4 Photographic evidence obtained. Class III	A 025		
A 026 SS=D	59A-36.007(2) FAC Resident Care - Social & Leisure Activities (2) SOCIAL AND LEISURE ACTIVITIES. Residents shall be encouraged to participate in social, recreational, educational and other activities within the facility and the community. (a) The facility must provide an ongoing activities program. The program must provide diversified individual and group activities in keeping with each resident's needs, abilities, and interests. (b) The facility must consult with the residents in selecting, planning, and scheduling activities. The facility must demonstrate residents' participation through one or more of the following methods: resident meetings, committees, a resident council, a monitored suggestion box, group discussions, questionnaires, or any other form of communication appropriate to the size of the facility. (c) Scheduled activities must be available at least 6 days a week for a total of not less than 12 hours per week. Watching television is not an activity for the purpose of meeting the 12 hours per week of scheduled activities unless the television program is a special one-time event of special interest to residents of the facility. A facility whose residents choose to attend day programs conducted at adult day care centers, senior centers, mental health centers, or other day programs may count those attendance hours towards the required 12 hours per week of scheduled activities. An activities calendar must be posted in common areas where	A 026		

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A 026	Continued From page 5 residents normally congregate. (d) If residents assist in planning a special activity such as an outing, seasonal festivity, or an excursion, up to 3 hours may be counted toward the required activity time. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing activities program, in keeping with each resident's needs, abilities, and interests, for 5 of 5 residents (#2, #3, #4, #5 and #6) living in the facility's memory care unit. Findings Included: During an interview with the facility's Activities Director at 9:48am on , she stated that she was the activities director for the assisted living residents who lived on the first floor of the facility. She stated that she had a monthly activities calendar, but that it was only for assisted living residents who lived on the first floor, not for the residents who lived upstairs in the memory care unit. The memory care residents had their own activities up in memory care, on the second floor. She stated that the memory care residents, at the time, did not have an activities director, and it had been a while since they last had one. She stated that on the memory care unit, the care staff were the ones conducting the activities for the residents, but she wasn't sure if they had a schedule or not. There were times when they had entertainment downstairs, which was usually about once a week, and the care staff would bring the memory care residents downstairs for those events.	A 026		

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A 026	Continued From page 6 In an interview with the in-house , , at 11:10am on , she stated she conducted an exercise class with the residents once a week, and a trivia game once a week. They had been holding the events downstairs on the front porch (which was open and unsecured). At times, some of the memory care residents would come down, brought down by memory care staff, as they had to be supervised. A tour of the memory care unit was conducted at 12:05pm on . It was observed that the memory care unit made up the entire 2nd floor of the facility. 5 memory care residents were observed being assisted upstairs on the elevator by care staff personnel, after eating lunch on the first floor. The memory care unit was observed to have 15 beds and a small living room area where activities would have been conducted. There was a memory care unit daily activity schedule observed, posted in a plastic document protector on a cabinet in the living room area. There was no monthly activity calendar observed on the memory care unit at that time. A review of the memory care daily activity schedule, on , revealed no date on the schedule. The daily scheduled activities consisted of the following: *7:30 - 9:00 breakfast *10:00 - 10:30 - morning exercise in courtyard *11:30 - 12:30 lunch *1:30 - 2:30 arts and crafts, music & refreshments *3:00 - 4:00 relaxation, naps *4:30 - 5:30 dinner *6:30 - 7:30 household activities: folding clothes, setting tables	A 026		

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A 026	Continued From page 7 While touring the memory care unit, an interview was conducted with the Director of Nursing, at 12:05pm on . She stated there were 5 residents living in the memory care unit, at that time. She stated that, in the memory care unit, household activities; such as folding clothes and setting tables (from 6:30pm - 7:30pm nightly, as listed on the daily scheduled activities) was an activity, as it kept them busy. At 12:15pm on , she posted a different memory care activities schedule on the bulletin board, upstairs, next to the elevator. During an interview with the Administrator at 4:50pm on , she stated that the memory care residents are brought downstairs to do exercises and activities everyday. She stated that all the memory care residents go down to the exercise classes on the open, unsecured front porch, under supervision. Photographic evidence obtained. Class III	A 026		
A 028 SS=D	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide care and services to meet the	A 028		

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A 028	Continued From page 8 needs for activities of daily living (ADL) care, for 6 residents (#2, #3, #4, #5, #6 and #8) of 10 who were interviewed or whose records were reviewed. Findings Included: An interview was conducted with the Activities Director at 9:48am on . In the interview, she stated that residents had frequently complained about not receiving assistance with showers. An interview was conducted with Staff B at 11:05am on , she stated that there were times when there were not enough staff to meet the needs of the residents. , , on nights and weekends when staff called off from work or when staff did not show up or work. She stated that not everyone was on the same page when it came to helping residents. A lot of staff did not follow a (care) routine. The staff were supposed to document when they assisted a resident with their shower, and the resident was supposed to sign the shower sheet after it was completed. In the memory care unit they had residents that needed toileting checks every 2 hours. The staff were supposed to document that they saw the residents every 2 hours, on a safety checks log. A review of the memory care 2 hour safety checks log, which covered the 2 hour toileting checks, was conducted on . The record showed that on , the memory care staff checked off for only 2 safety checks the entire 24 hour period (7:00am and 9:00am), for all 5 residents living on the unit, and the log was not signed off by any of the care staff. The record showed that on , the memory care staff checked off for only	A 028		

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A 028	Continued From page 9 5 safety checks the entire 24 hour period (7:00am, 9:00am, 11:00am, 1:00pm and 3:00pm). The record showed that on (at 12:05pm on) there were no safety checks signed off at all for the entire day, since it began at 7:00am. In an interview with Resident #8 at 12:38pm on , she stated that she was supposed to have assistance with her showers, but the staff didn't always come to help her. On , she had a male staff person come by to ask if she were comfortable with a male staff assisting her shower. She told him no, she was not comfortable with that. She was not sure that anyone else would come and offer assistance with her shower that day. She stated that when she had requested assistance by pulling her call button cord, she had waited 2 hours, and then the aides would just shut it off without ever coming to assist her. She said she reported it to the Director of Nursing. She stated that the first 5 years of living at this facility were wonderful, but since a new company bought it, it went downhill. She even wrote a grievance letter to the corporate office, and they never responded. A review of the notes from resident council meeting, held on from 1:40pm - 2:15pm, revealed comments from the resident attendees, that the staff in the facility had an uncaring attitude. A review of the staffing schedule on revealed that there were no care staff scheduled on the memory care unit for for the 11:00pm - 7:00am shift and on on for the 3:00pm - 11:00pm shift. There were no staff scheduled on the memory care unit for and on	A 028		

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A 028	Continued From page 10 the 11:00pm - 7:00am shift, and no staff scheduled on the memory care unit for on the 7:00am - 3:00pm shift. Photographic evidence obtained. Class III	A 028		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free	A 030		

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A 030	Continued From page 11	A 030		

telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.
(d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding:
1. Resident responsibilities;
2. and tobacco use;
3. Medication storage;
4. Resident elopement;
5. Reporting resident , neglect, and , ;
6. Administrative and housekeeping schedules and requirements;
7. control, sanitation, and standard precautions;
8. The requirements for coordinating the delivery of services to residents by third party providers;
9. Assistive devices; and
10. Physical .
(e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws.
(f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d),

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A 030	Continued From page 12 F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue	A 030		

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A 030	Continued From page 13	A 030		

the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case

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of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where

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complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident.

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

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A 030	Continued From page 16 failed to facilitate the presentation of residents' grievances in order to recommend changes in policies, procedures, and services in order to resolve the grievances. In addition, the facility failed to follow its own grievance policy and procedure. Findings Included: An interview was conducted with the Administrator on at 9:20am, she stated that she had been working in the facility for about 2 years, and so far there had been no grievances. She stated that no one has come to her with any grievances or complaints. An interview with Staff A at 9:35am on was conducted and she was asked where the grievance policy was posted. She stated she said she did not know, and acted like she had no idea what a grievance even was. An interview was conducted with the Activities Director at 9:48am on . In the interview, she stated that residents had frequently complained about not receiving assistance with showers. A review of the facility's grievance policy on , revealed it encouraged residents, family members, responsible parties or interested parties to express their concerns, without any fear of retaliation. And that they (the facility) would address concerns in a timely manner and give residents, family members, responsible parties, and interested parties, a satisfactory resolution to their concerns. The grievance policy stated that there would be a copy of the grievance procedure posted in a prominent location of the facility. The	A 030		

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A 030	Continued From page 17 policy stated that the Administrator would respond to the party as soon as possible, and document the response. A review of the facility's grievance log on , revealed no log sheet, and no log entries, only a blank plastic page protector where the grievance log would have gone. A tour of the facility was conducted on at 9:30am. Observations on the tour revealed that the most prominent area of the facility, was the front lobby area, near the front door where a receptionist desk was located, a gathering room with tables and chairs for playing games and visiting, and a hallway where offices, such as the sales and marketing office were located, as well as the dining room, all within close proximity of each other. There was no sign or any information seen that had any information instructing anyone on how to file a grievance. In an interview with Resident #8 at 12:38pm on , she stated that she was supposed to have assistance with her showers, but they didn't always come to help her. She stated that when she had requested assistance by pulling her call button cord, she had waited 2 hours, and then the aides would just shut it off without ever coming to assist her. She said she reported it to the Director of Nursing, and nothing was done about it. She stated that the first 5 years of living at this facility were wonderful, but since a new company bought it, it went downhill. She even wrote a grievance letter to the corporate office, and they never responded. A review of the notes from resident council	A 030		

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A 030	Continued From page 18 meeting, held on from 1:40pm - 2:15pm, revealed comments from the resident attendees, that the staff in the facility had an uncaring attitude. Photographic evidence obtained. Class III	A 030		
A 093 SS=D	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, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. 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	A 093		

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A 093	Continued From page 19 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 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.	A 093		

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A 093	Continued From page 20 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 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.	A 093		

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A 093	Continued From page 21 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to post the planned menus, so that they were easily available to residents, and failed to maintain a 3-day supply of nonperishable food, stored safety without refrigeration. Findings Included: A tour and observation of the facility dining room at 11:45am on , revealed the menus posted in the dining room, near the entrance to the kitchen, were outdated. The menus were marked as being from and winter of 2023 and 2024, and they were not signed or dated by a dietician. An observation of the emergency food supply at 1:00pm on , revealed that it was not sufficient and was not stored as exclusively emergency food. In an interview of the activity's director, she reported she had no idea where the emergency supply food was going or why the cases were opened, as they should not have been used for another purpose. There was insufficient water observed for the 3-day emergency supply. There were no water available for water storage. In addition, the storage room, the "hurricane" room, where the emergency food was being stored, was not exclusive to emergency food storage. There were catering supplies, clothing, tables and chairs and other items. The emergency foods were not distinguishable from other food and paper products being used for daily use. There wass cereal with no dried or canned milk product. In an interview with the Activities Director, at	A 093		

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A 093	Continued From page 22 1:05pm on , she stated that the menus posted in both the dining area and the kitchen were the original menus that came from corporate. She reported she had no idea where the emergency supply food was going, or why the cases of food in the emergency food supply were opened. She stated there was a budget for food and the facility did not have sufficient money to buy more cases of the water and there were no water available for water storage, to be used in an emergency. In an interview with the Administrator, at 5:00pm on , she stated that she got the menus directly from the company website. Class III	A 093		
A 094 SS=D	59A-36.012(3) FAC Food Service - Food Hygiene (3) FOOD HYGIENE. Copies of inspection reports issued by the county health department for the last 2 years pursuant to rule 64E-12.004, or chapter 64E-11, F.A.C., as applicable, depending on the licensed capacity of the assisted living facility, must be on file in the facility. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen, where all of the residents' food was prepared, in a safe and sanitary manner, which had the potential for causing food-born illnesses in 37 of 37 residents living in the facility. Findings Included:	A 094		

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A 094	Continued From page 23 A tour of facility kitchen at 1:00pm on was conducted. It was observed that the dry storage room was in complete disarray. Many of the open foods were not properly closed or dated. There was flour being stored in a bin on the floor, with the lid hanging off the side and it was open to potential contaminants. In the storage area, a cheese product was observed, that had been opened and was neither properly stored or dated. There was a red liquid observed on the floor. The was garbage observed on the floor. There was food observed improperly stored on the shelves, and a box of sausage meat that had been opened and not properly closed up or dated. Bacon was found in the storage area, in a metal pan and not dated. A metal pan with an unknown substance was observed on top of the pan of bacon, also not dated. In the ice cream freezer, none of the ice cream was covered and there was ice cream smeared throughout the case and on the lid of the freezer. In the food preparation area, the floor was soaked with water and the floor also contained food particles, some dishes and some eating utensils. The Kitchen Manager was observed pulling pork, in a metal pan, directly above a box of bananas, open loaves of bread, and an open plastic container of peanut butter. The washing sink directly next to the entry door was broken, unable to stop the water flow, as it was leaking. The floor in the storage area for pots and pans was littered with packets of crackers and other food materials. A dirty broom and dust pan was observed laying on the floor, next to what appeared to be clean pots and pans. At 1:15pm on , in an interview, the Kitchen	A 094		

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A 094	Continued From page 24 Manager stated he was unable to make a determination of how long the food had been there (and not stored correctly). He also stated (when asked about pulling pork meat directly above the bananas, peanut butter and uncovered bread) that he knew that it was cross contamination. A review of the Department of Health report from an inspection on revealed an unsatisfactory inspection with areas of violation of health and sanitary food practices. In an interview with the Administrator at 5:00pm on , she blamed the Kitchen Manager for the poor kitchen hygiene. Photographic evidence obtained. Class III	A 094		