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
	AL11969028	A. BUILDING: _____ B. WING _____	09/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 re-licensure survey and generator monitoring was conducted at Zon Beachside LLC. Assisted Living Facility and Memory Care with Extended Congregate Care (ECC) on . . . . The facility had deficiencies at the time of the survey visit.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident,	A 010		

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A 010	Continued From page 1 additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the	A 010		

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A 010	Continued From page 2 applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's	A 010		

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A 010	Continued From page 3 record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities	A 010		

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A 010	Continued From page 4 holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to update residents Health Assessment Form (1823) within 30 days of a significant change for 2 of 7 residents sampled (#5 & #9) as required. Findings: 1. On a review of resident #9 record revealed she was admitted on . She was under hospice care. Her record contained a Resident Health Assessment Form (1823) dated . The 1823 documented the resident required assistance with all activities of daily living except eating for which she was independent. Further review of resident #9 record revealed a hospice note documented on for care to the right heel for an unstable . On a note documented by the hospice nurse documents for safe transfer and right heel black and softening left heel with small dark area. Resident #9 was observed with the hospice nurse. The nurse was changing resident #9 to lower extremeties. She said they were ordered due to and a on the right heel. She confirmed resident #9 was total care and needed a to transfer. Caregivers J and A were in the room assisting with AM care. They used a to transfer resident to a high wheelchair. On at 2:40pm in an interview with caregiver A. She said resident #9 had on her heels. She was . She	A 010		

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A 010	Continued From page 5 said it always takes 2 staff to assist with transfer using the , because resident #9 was unable to bear any . On at 3:10pm The DON confirmed resident #9 had a decline in function more than 30 days ago. She said the resident declined within weeks of being admitted on . She confirmed resident #9 1823 was not updated with total care or , . 2. Resident #5's record review revealed admission date of . The last 1823 Health Assessment dated listed medical history of , history of , ,), fatigue, , , valve , , and irritable . She needs assistance with activities of daily living (ADLs) in bathing. Supervision with ambulation, and toileting. Indpendent with eating, grooming and transferring. She needs assistance with self-administration of medications. There was no new 1823 Health Assessment completed that documented Resident #5 was a risk after eight (8) from period . The last 1823 Health Assessment dated documented no special precautions applicable. On at 2:55 PM, an interview with the Director of Nursing (DON) confirmed the findings. (Photographic Evidence Obtained) Class III	A 010		

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A 025	Continued From page 6	A 025		
A 025 SS=G	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 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.	A 025		

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A 025	Continued From page 7 (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 observation, interview, and record review the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision to prevent multiple . . . with injuries for 3 of 7 residents sampled (Residents #5, 10, 13). Findings: 1. A review of resident #10 record revealed on Saturday . . . at 12:23am resident #10 tripped over his scooter when returning from the bathroom landing on his left side. He got himself up and did not notify staff. On . . . . at 10:30pm resident #10 requested , . . medication from nurse (D). He said he had . . because he had . . . earlier and had not reported it to anyone.	A 025		

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A 025	Continued From page 8 On mobile , confirmed resident #10 had a left , . He was transferred to the hospital, and he returned the same night with orders for , medication and orthopedic follow-up orders. His , , was scheduled for . The resident was educated to place the scooter in a safer place and alerting staff of incidents. On at 12:40pm resident #10 was observed in his room. In an interview he said he did not need any assistance. He said he was able to transfer and used his motorized scooter to go long distances. He said he used a walker in his room. A review of resident #10 record revealed he was admitted on . His record contained a Resident Health Assessment form dated . He required assistance with all activities of daily living. He was alert and oriented. He had a which he was able to maintain. He required assistance with self-administration of medications. He was at risk for , and . A review of the facility notes found: On a documented at 6:01pm by nurse (D) walking past room saw him lying on the floor in his doorway. He said he just . Assisted up off the floor into wheelchair. On a documented by nurse (F) - slipped on a piece of paper and . Superficial noted to lower . On a documented at 11:49pm by nurse (D) - Resident told the nurse he today onto his left side. No discoloration, redness or noted. On a documented by nurse (F) -	A 025		

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A 025	Continued From page 9 Resident observed lying on left side next to toilet. He said he felt weak and Review of a hospital note found documentation on -closed of the greater of left . Not an acute surgical . Follow up with orthopedic. The DON confirmed resident #10 sustained multiple with injury. She could not provide documentation on mitigating strategies. She said the staff do check on resident #10 at least every 2 hours. Those checks are not documented. 2. A review of resident #13's record revealed a facility admission date of . The resident's medical history included of right . The resident needed assistance with self-administration of medications. The resident received hospice services. A review of resident #13's chart revealed she had multiple ( ). One of which resulted in a higher level of care, ( ), resulting in the resident needing 5 staples to the left side of her . On at 3:40 pm, the director of nursing (DON) confirmed the findings and was unable to provide additional documentation. 3. Resident #5's record review revealed admission date . The last 1823 Health Assessment dated listed the medical history of , history of , ( ), fatigue,	A 025		

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A 025	Continued From page 10 valve, and irritable. She needs assistance with activities of daily living (ADLs) in bathing. Supervision with ambulation, and toileting. Independent with eating, grooming and transferring. She needs assistance with self-administration of medications. In further review, there were no special precautions indicated for eight (8) in the last six months beginning -. A facility note dated at 3:10 AM-1st, nurse E documented Resident #5 was found sitting on her bathroom facing the doorway. Resident #5 stated that she got up to use the bathroom and tripped and straight down onto her hitting her and right cheek on the floor. She hit her right arm on the way down causing a large to it. Her right cheek was, and it was painful to touch and had a broken front. Resident #5 was alert/oriented and stated she never lost and was able to move all extremities freely. Assessment completed. Resident #5 was sent out to hospital for evaluation. There was no documented evidence that the legal responsible party and physician was notified about the and there was no precaution interventions put in place. A facility note dated at 11:16 PM-2nd, nurse G documented Resident #5 was found sitting on the floor near the kitchenette with against cabinet. Observed large to right arm 9 cm in length and small to left, both injuries were cleaned and dressed. Resident #5 was assisted off the floor by two staff to her chair and denied hitting her.	A 025		

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A 025	Continued From page 11 There was no documented evidence that the legal responsible party and physician were notified, and no precaution interventions put in place. A facility note dated at 6:54 AM-3rd , nurse G documented Resident #5 pushed pendent earlier at 4 AM, and was found down on the floor with on her forehead. It was asked if she hit her , and she said yes. Resident #5 said she was trying to walk with walker to use the bathroom (slurring) with her gait unsteady and . Resident #5 agreed to go to the emergency room for evaluation and . Notified brother and physician. There was no documented evidence of any precaution interventions put in place. A facility note dated at 7:51 AM-4th , nurse G documented Resident #5 on and hit her hard and complained of severe hematoma formed. Resident #5 stated , level was 7 out of 10. Vitals checked, normal range. The physician was notified and left a voicemail message with brother. Resident #5 was sent out to hospital. There was no documented evidence of any precaution interventions put in place. A facility note dated at 10:31 PM-5th , nurse D documented Resident #5 told nurse D that she the other day while she was out with her niece and Resident #5 cracked her left result of the . Resident #5 went to see a doctor , while she was already out of the facility and physician confirmed that Resident #5 had a crack in her . No	A 025		

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A 025	Continued From page 12 surgery was necessary, and it will take 6 to 8 weeks to heal. New orders: , 325mg and staff may need to assist with and assistance to Resident #5. Resident #5 stated she has difficulty with putting on her bra. Resident #5 denied , at this time. There was no documented evidence, and no documented service plan completed to indicate increased assistance with activities of daily living with . A facility note dated at 6:46 AM-6th , nurse E documented Resident #5 was found on her near her bed on the floor. Resident #5 stated that she had rolled over and slid out of her bed onto the floor. Resident #5 denied any , and denied hitting her . Resident #5 was assisted up off the floor and placed into bed. Vitals signs checked, normal range. There was no documented evidence that any precaution interventions were put in place. A incident was report dated at 10:15 AM that Resident #5 was on her way out with a friend and Resident #5 tripped and in the lobby. Resident #5 had a on the of her that required staples being transported to the hospital. Resident #5 stayed one night at the hospital for further observation after the . Resident #5 did not have any A facility note dated at 10:58 AM-7th , nurse I documented Resident #5 in the lobby area lying on her with pooling from under her . 911 called and Resident #5 was taken to the hospital via stretcher. A voicemail message was left with the physician.	A 025		

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A 025	Continued From page 13 The brother was notified. A hospital note dated at 9:47 PM documented Resident #5 had a hematoma to of and 5 stitches administered to close and additional brace support recommended for Resident #5 to wear for the next 6 to 8 weeks. A facility note dated at 7:35 PM, nurse D documented Resident #5 returned to the facility at 4:25 PM. New orders of , 15 milligram (mg) prescribed and , ( ) with Home Health agency twice weekly. Vitals checked, normal range. Resident #5 was wearing a soft collar brace only for bed and wearing the hard brace when up and moving around. A facility note dated at 4:47 AM-8th , nurse G documented Resident #5 pressed her pendent at 4AM. Resident #5 was found on the floor lying on her left side and she stated she didn't know what happened and it was asked if she was in , and she answered right , and right , left , and . Vital signs were normal. Resident #5 stated could not bear on her right , and right . 911 called and Resident #5 transported to the emergency room. Physician and family called. Further review revealed, resident #5 was admitted into the hospital at 2:37 PM for a at an unknown body location. On at 5:10 PM, an interview with the Director of Nursing (DON) confirmed the findings. (Photographic Evidence Obtained) Class II	A 025		

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ZON BEACHSIDE LLC	1894 S PATRICK DR INDIAN HARBOR BEACH, FL 32937

(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 14	A 032		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must 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 trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the	A 032		

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A 032	Continued From page 15 resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate 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 must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, facility's documentation review and interview, 1) the facility failed to make a minimum daily effort to determine that 1 of 7 sampled residents (#1) have identification on their persons to include the resident's name, the facility's name, facility's address and facility's telephone number for residents high risk for elopement; and 2) the facility failed to have a complete elopement policies and procedures that include elopement assessment to completed for high risk for all elopement residents and continued care intervention to prevent elopements; and 3) the facility failed to ensure that 2 of 5 sampled staff (A & Director of Nursing)	A 032		

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A 032	Continued From page 16 participated in two elopement drills in year 2023 as required. Findings: An observation on at 11:36 AM, Resident #1 was not wearing identification and did not have identification on her persons to include her name, facility name, facility address and facility telephone number in case she elopes from the Memory Care unit. Resident #1's record review revealed admission date . The last 1823 Health Assessment dated listed the medical history of Uncontrolled history, with (long term use); Aphasia, risk, with , and history of acute Hypoxic failure. She needs assistance with bathing, , grooming and toileting with activities of daily living (ADLs) and supervision with ambulation, eating and transferring. She needs assistance with self-administration of medications. In further review, Resident #1 was identified as an elopement risk and was recently admitted on Hospice care on . A review of the facility's elopement policies and procedures A0035, effective date was not complete. The elopement policies and procedures did not document interventions for an elopement risk resident after found by staff or local law enforcement agency. (Photographic Evidence Obtained)	A 032		

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A 032	Continued From page 17 On .. .. at 4:10 PM, an interview with the Administrator confirmed the findings. A review of staff A's record revealed she was hired on . . . . . Her record did not contain any documentation of participation in elopement drills for the calendar year of 2023. On .. .... at 5:25pm the DON confirmed the findings. A review of the Director of Nursing's record revealed she was hired on . . . . . Her record did not contain documentation of participation in 2 elopement drills in 2023. Class III	A 032		
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	A 093		

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A 093	Continued From page 18 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 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	A 093		

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A 093	Continued From page 19 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 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	A 093		

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A 093	Continued From page 20 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 observation, facility's documentation and interview, the facility failed to have the approved menus signed annually by the registered dietician that were planned in at least a week in advance as required. Findings: An observation on at 11:44 AM, there was no approved meal menu posted and available for residents in the Memory Care to review. An observation on at 12:15 PM, the facility provided a daily menu of the meal to be served today on the resident's table or at resident's request for a menu. The lunch menu being served today of choices below: a) Entree: Baked Cod fish with Lemon sauce, coocoos (rice), and steamed vegetables or Korean Meatballs in mild chili sauce, lo Mein noodles, and stir fry vegetables. b) Dessert: Lemon Meringue c) Soup of the moment: Creamy Butternut d) Classic Pepperoni Pizza (pepperoni, marinara sauce, fresh basil, mozzarella cheese and tomatoes) There were no menus available or posted for a	A 093		

Agency for Health Care Administration

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A 093	Continued From page 21 week in advance. There were no menus approved by a registered dietician annually provided. On [redacted] at 12:45 PM, an interview with the Food Director confirmed the findings. He also stated that he was new to working at the facility. (Photographic Evidence Obtained) Class III	A 093		