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
	AL11910126	A. BUILDING: _____ B. WING _____	R 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ALTAMONTE SPRINGS	433 ORANGE DRIVE ALTAMONTE SPRINGS, FL 32701

(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 revisit to a complaint investigation #2024016355 and generator monitoring was conducted at Grand Villa of Altamonte Springs from - . The facility had uncorrected deficiencies at the time of the survey.	{A 000}		
{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 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	{A 030}		

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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), 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

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{A 030}	Continued From page 2 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 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	{A 030}		

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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 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

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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 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

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{A 030}	Continued From page 5 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: DEFICIENCY REMAINED UNCORRECTED Based on observation, record reviews and interviews, the facility failed to treat residents with consideration and respect when it failed to respond in a timely manner to calls for assistance from 3 of 6 sampled residents (2, 5, 15) and failed to investigate and follow its grievance policy when 1 of 6 sampled residents (4) alleged theft of personal items.	{A 030}		

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{A 030}	Continued From page 6 Findings: 1. Review of resident #2's record revealed a facility admission date of . The resident's medical history included ( ) with left , and a six . A health assessment form (1823) indicated the resident's or behavioral status was within normal limits. On at 10:05 am, the resident said he from his bed on at approximately 4 am then pressed his call pendant. No one responded. The resident's roommate, resident #1, then pulled the emergency bathroom cord and no one responded. Resident #1 went upstairs and found a caregiver, who called another staff member to get resident #2 off the floor. Neither of them could, so the fire department was called and were able to get the resident up. Resident #2 said he did not sustain injuries from the . Review of resident #2's call report revealed his pendant was pushed on at 2:57 am then cleared at 4:16 am for a total wait time of 79 minutes. There was not an emergency bathroom cord call on the report. Review of the resident's record revealed there was not a note of the incident. On at 2:20 pm, the administrator said there was no documentation of the incident in the resident's record. On at 3 pm, unlicensed caregiver H said that on at approximately 4 am resident #1 came to the second floor and told her resident #2 . The caregiver responded to the room and	{A 030}		

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observed resident #2 laying on his on the floor next to his bed. The caregiver asked a caregiver working in memory care to help the resident up. In the meantime, resident #2 called emergency medical services (,) who arrived and got resident #1 up. Caregiver H called the on-call manager, the name of whom she could not recall, who instructed her to write a report and call the manager if resident #1 went to a hospital. The caregiver said that when resident #2 came to her she recalled hearing the emergency pull cord over her radio. She said she never heard the pendant call. She said she was able to meet all the residents' needs while working by herself overnight.

On at 3:20 pm, a request was made to the administrator to provide the report that showed the emergency pull cord call.

On at 4 pm, caregiver H said she recalled resetting resident #1's pendant on . When asked by the agency for healthcare administration (AHCA) surveyor how she knew to reset it if she did not hear it over her radio she responded because resident #2 told her both the pendant and emergency pull cord were used to call for help.

Review of caregiver H's report of the incident revealed that at approximately 3 am, she was made aware of resident #2's by resident #1 and by the radio calls. Resident #2 got up to use the bathroom, lost his balance then . was called.

There was no documentation about helping the resident off the floor.

On at 4:30 pm, the administrator said

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there was no emergency pull cord call on . He said he was checking to see if the system labeled the call as pendant when it was really the pull cord.

2. Review of resident #5's record revealed a facility admission date of . The resident's medical history included . A 1823 indicated the resident needed assistance with self-administration of medications.

On at 9:30 am, upon entering resident #5's room with unlicensed caregiver B to observe a medication pass, the resident held up the call pendant around her and said, "it doesn't do any good to use this, does it?" The caregiver leaned over, reset the pendant and said, "I'm sorry, I was helping other residents."

On at 10:41 am, resident #5 said she thought there were not enough staff which was why it took so long to answer her pendant calls. When asked by the AHCA surveyor for specifics on how long she had to wait she responded that she did not want to get anyone in trouble, but it just took too long. She said she experienced left so every morning fifteen minutes before her medication was due at 8 am she pushed her pendant just to let them know she was ready for it. She described her level that morning as 6 on a scale of 1 to 10 with 10 being the worst. She said that on she did not get her medication until approximately 11 am and the person who brought it said there was no one working until she got there.

On at 2:05 pm, unlicensed caregiver C said there was not a staff member available to give medications at the start of the 7 am shift on . He said nurse E started giving

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medications when she arrived until a staff member from memory care came over. He said unlicensed caregiver D came in early to help.

On at 11 am, unlicensed caregiver D said she arrived at work on at around 11 am to give medications.

On at 10:07 am, unlicensed caregiver F said she was the person who came over from memory care to give medications on . She said she arrived to help at approximately 10:30 am after she finished giving medications in memory care. She did not know why she had to help, she thought someone did not show up or called off. She said resident #5 was accurate when she said she received her medications at around 11 am. The caregiver said the resident asked why they were given so late so the caregiver told her she had to come over and help and she was going around as fast as she could.

A review of resident #5's call report revealed her pendant was pushed on at 7:45 am then cleared at 11:17 am for a total wait time of 212 minutes. On her pendant was pressed at 7:36 am then cleared at 9:35 am for a total wait time of 119 minutes. On at 5:43 pm her emergency cord was pulled at 5:43 pm then cleared at 7:10 pm for a total wait time of 87 minutes.

On at 1:25 pm, resident #5 said she pressed her pendant and not the emergency cord to call on at 5:43 pm to get her scheduled , medication. The AHCA surveyor asked her to press the pendant, which could be heard coming over the staff radios.

On at 1:33 pm, I was asked by the AHCA

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{A 030}	Continued From page 10 surveyor if the facility had enough staff to meet the residents' needs. She replied "I can't answer that. I can't tell you who's coming on board. You'll have to talk to the memory care director, the resident care manager, or the administrator." When asked if there was enough staff to meet the needs of the residents, such as adequate supervision to prevent , assist with toileting needs and give medications on time she replied "once again, I don't know. That's a loaded question. There's a lot to that question." On at 10:53 am, the resident care manager said she was not on call on so she did not know anything about someone calling off or not showing up for work. When asked by the AHCA surveyor what measures the facility put in place as part of its previous correction to call response times, she said the call system company started sending her, the memory care director, and the administrator, a report showing all calls made during the previous day. She said she used the report to question staff about any calls that took more than seven to ten minutes to respond. She said she did not document this process. She said some of her findings thus far included some broken pendants and determining caregivers were giving care to other residents when the calls occurred. When asked if there were enough staff to meet the residents' needs, such as answer calls in a timely manner and give medications on time, she responded that caregivers had expressed to her the need for more staff. She said the administration said they would look at the staffing numbers to see if more staff can be added. She said she pulled the call report for resident #2's and she was going to call the caregiver but had a medical condition occur on so she couldn't. She learned about arriving at the facility after	{A 030}		

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resident #2's from the AHCA surveyor. She said she would have found that out when her investigation into the was complete.

On at 12:07 pm, unlicensed caregiver C said the facility's policy on responding to the pendant or emergency calls was within five minutes. He said any resident call, regardless of which building the resident lived in, went to all facility radios. He said if a call was not answered within five minutes, he called another staff member to respond or he answered it himself. He could not recall if he heard resident #5's calls on and .

On at 12:43 pm, unlicensed caregiver B said she did hear resident #5's pendant call on the radio on , but she was passing medications to other residents at the time. When asked the procedure for responding to calls she replied, "I should see the resident to see what she needs and make sure I turn it off before I leave the room." She believed there was enough staff working during her shift to meet the needs of the residents.

On at 1:06 pm, the resident care manager said a staff member called off on , which was why someone had to come from memory care to help give medications.

On at 3:13 pm, the regional director of operations said the facility did not have a policy on pendant and emergency call responses.

On at 3:30 pm, nurse E said she did not remember if she heard resident #5's pendant call on . The nurse said if a pendant call occurred more than once she called a staff member to respond or she responded to the call

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{A 030}	Continued From page 12 herself. On at 3:37 pm, resident #2's pendant and emergency cord were tested, and both were heard on the staff radios. On at 2:24 pm, the administrator confirmed receiving a call report every morning, which he said included the total calls received and additional details for any response times over fifteen minutes. He said the resident care manager was responsible for reviewing them. He said if there was a pattern involving specific staff corrective action was taken. He did not instruct the resident care manager to document this process. He believed any staff complaints about staffing had to do more with certain staff than with the staffing levels. He said he reviewed the staffing levels based on the resident care manager reporting the caregiver's concerns and he did not find instances where residents did not receive care, their medications on time or with meals for example. 3. Review of resident #15's chart revealed a facility admission on . A 1823 health assessment indicated a medical history of , acquired absence of left below , and has intermittent forgetfulness. Resident #15 was asked if she had any issues when pulling her call cord and staff not responding timely. On at 10:06 am, resident #15 stating, I only recall pulling the cord when the bed frame came off the wall. I don't recall pulling the cord when I needed assistance for care. I have (,) and I forget sometimes of	{A 030}		

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things that happened. Maybe someone else pulled it. The resident's roommate stated, I pulled her cord once. I believe it was in , around the time she moved it. No one came so I went out into the hallway to look for someone. They came, but it took a while. She was soaking wet and needed to be changed.

A facility note on at 1:30 pm move-in summary read, Resident arrived at community on at approx. 4:12 pm. Resident was educated on the call light system and to utilize for emergencies or any urgent care needs.

A facility note on 9:00 am read, toileting (independent with encouragement as needed) Resident needs assistance with this task, specially overnight, she was soaking wet this morning. Needs to be checked at least twice during the night.

On at 2:00 pm, unlicensed caregiver A stated, resident #15 is a fairly new resident. Resident #15 requires a lot of assistance. She pressed her pendant today because she pooped, and it was everywhere and needed a shower. The morning times are worst because she doesn't have her , on and can't get up quickly so she wets her , and bed. When a resident presses their call pendant I go. If I'm by myself they have to wait a little longer and I let the other resident know I'm with someone and I'll be right there.

On at 1:40 pm, resident #15 stated, as long as I have this on (pointing to her ,). I'm able to take myself to the restroom. It's when I don't have it on in the middle of the night, I'll call for help. The staff usually puts extra padding on my bed for overnight because I can't make it to

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the bathroom. I have and it's like I have no control so I just go in the bed.

A review of resident #15's call pendant report revealed the following:

Location: , Type: pendant, Level 1, Occurred 12:23 pm Cleared 1:04 pm, Response Time: 41:00
Location: , Type: pendant, Level 1, Occurred 6:52pm Cleared 7:26 pm, Response Time: 34:00

The resident was asked if she recalled the 2 days of pushing her pendant and the long response times.

On at 10:04 am, resident #15 stated, I don't remember those days. I honestly try to take care of myself. I know for sure I pulled it twice because I had a blowout and needed to be changed and given a shower. It may have been last week. With my , I don't always remember. I know I had an accident after lunch one day.

The resident care manager was asked about the long response times for resident #15.

On at 1:07 pm, the resident care manager stated after reviewing the call pendant report. Honestly, I don't know. I can try to investigate, but I don't know anything about those dates. I believe it would have been caregiver K on . On , no one was assigned, so I believe nurse J took the cart, but I don't want to say for certainty. The RCM followed up with the memory care director to obtain a copy of the schedule. Upon returning to the private dining room the RCM stated it wasn't nurse J it was caregiver L who worked 7 - 3 pm on . She's the one who

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{A 030}	Continued From page 15 signed off on the meds and was on the timecard. She works PRN (as needed). On at 1:42 pm, caregiver L was contacted via phone and left a voice message for a call . On at 1:47 pm, caregiver K was contacted via phone and left a voice message for a call . On at 10:59 am, a second attempt was made to contact caregiver L. On at 11:12 am, caregiver K stated during a phone interview, I don't recall that day (referring to) when asked about the 34 minutes response time for resident #15. Caregiver K stated, when we're with another resident we call someone on the radio to go assist like the nurse or another caregiver. I don't recall that day for resident #15, so I don't know why the response time was 34 minutes. On at 11:12 am, caregiver L stated during a phone interview when asked about the long response time for resident #15 on . She stated, around that time, I was with resident #15 who was lactose intolerant. She had cheese that day for lunch and she was by the ramp and had poop down her . She's the resident with the . I helped her to her room to get her cleaned up. I had to put her in the shower. When I realized and heard her pendant. I turned it off. So, yes, it's possible it was going off for 41 minutes, but I was with resident #15 the entire time. If I hear another pendant going off. I radio to tell another staff I'm with a resident. The administrator was asked when the facility	{A 030}		

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{A 030}	Continued From page 16 began obtaining the call report and the name of the system. On at 3:05 pm, the administrator stated the facility started getting reports from Care Link each morning beginning via an automatic email. He stated the report is reviewed to determine if discipline is needed when the light is greater than 15 minutes. After review, it's related more to each staff individually because it's not all staff that has an issue with responding to the resident and providing care. The administrator was made aware that the resident care manager stated she didn't know anything about resident #15's response times and would have to do an investigation. 4. Review of resident #4's record revealed a facility admission date of and discharge date of . On at 5:15 pm, nurse I documented that at approximately 2 pm a police officer arrived at the facility because resident #4 called them. The resident said his identification (ID) and cards were stolen approximately four months prior and said, "the people that run this place do not care." The resident also told the officer that he was unable to go and buy anything because he did not have his cards. The power of attorney (POA) was notified. There was no documentation in the record to indicate the facility conducted its own investigation into the residents' allegation. On at 11:09 am, the person listed first as POA on the resident's sheet said when she was unable to continue as POA, the resident's	{A 030}		

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{A 030}	Continued From page 17 family member became his responsible party. The POA was unaware of the missing ID and wallet and believed the now responsible party would have been who the facility told. On at 11:17 am, the responsible party said they learned of the missing wallet and ID from the administrator much later after it happened. The responsible party said the resident did have an ID and social security card in his room. The responsible party last saw the items during a visit with the resident in . On at 2:26 pm, the administrator said he did discuss the missing wallet with the responsible party. The administrator said the responsible party said they learned about it from the resident and they thought the items were only misplaced. When asked if the facility investigated the resident's allegations of theft, the administrator said he would have to check with the resident care manager. On at 4:20 pm, the resident care manager said an investigation into the allegations was not conducted because the responsible party took those items home with them a long time ago. The resident care manager said there was a time when the resident accused people of taking all kinds of stuff. The resident care manager said the responsible party took the items sometime prior because the resident tried to buy a car. On at 11:52 am, the responsible party said they never told the resident care manager they took the resident's items home with them. The responsible party said no one from the facility told them the resident called the police.	{A 030}		

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{A 030}	Continued From page 18 On at 12:58 pm, nurse I could not recall which POA or responsible party she called when the resident called the police and reported the items stolen. The facility's grievance policy and procedure, revised , indicated a grievance investigation should include evaluation of the nature of the grievance, review of pertinent records, review of follow-up, review of related policies and procedures for compliance, and identification and interviews of appropriate individuals and witnesses involved. The details of the investigation and how it was resolved must be documented in the resident's observation log. (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	{A 093}		

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{A 093}	Continued From page 19 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 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	{A 093}		

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{A 093}	Continued From page 20 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 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.	{A 093}		

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{A 093}	Continued From page 21 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: DEFICIENCY REMAINED UNCORRECTED Based on observation, record review and interview, the facility failed to note meal substitutions before or when the meal was served. Findings: On at 12:10 pm, clam chowder, grouper, spaghetti with tomato meat sauce, broccoli, mushroom and zucchinis and a roll were served for lunch. Review of the menu revealed lunch was supposed to be beef barley soup, herb crusted tilapia and glazed carrots. The only noted substitution was the grouper. On at 1:40 pm, the chef said carrots were not served because the residents said they were too hard. He said the beef barley soup was not served because he wanted to give a variety of soup. He said the residents did not like tilapia, so he substituted it with grouper. He said he did not document the substitutions for the soup and carrots because his regional chef told him he only had to document the protein substitute. Class III	{A 093}		