

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Bay Breeze Senior Living and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3387 Gulf Breeze Parkway Gulf Breeze, FL 32561	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Based on interviews, record review, and policy review, the facility failed to ensure that 2 of 4 residents' family members was notified of a significant change in condition and subsequent transfer to the hospital, as required by facility policy and regulatory expectations. (Resident #2 and #4) During a 04/01/2026 interview at about 2:00 PM, Employee G (a Registered Nurse) stated that she completes the Situation Background, Assessment, Recommendation (SBAR) form and uses the communication book during any hospital transfer. However, she was unsure who is responsible for notifying the resident's representative about a change in condition, stating that she believed the supervisor handled those calls. During a chart review and interview on 04/01/2026 at approximately 3:45 PM with the Assistant Director of Nursing (ADON), it was stated that staff are expected to notify family of any change in status and document this in the SBAR Template and progress notes. However, 2 of the 4 sampled residents did not have documentation showing that family had been notified during a change in condition and transfer to the hospital. The records of Resident #4, who had a change of condition on 01/01/2026, and Resident #2, who had a change of condition on 02/18/2026, showed only that the residents themselves were notified, with no documentation indicating that they refused family notification. The ADON confirmed that required family notification was missing from both records. During an interview with the family of Resident #2 on 04/01/2026 at approximately 6:39 PM, she reported that the facility failed to notify them about lab results, tests, changes in condition, or the transfer and hospitalization that occurred on 02/18/2026. She stated that the family only learned of the situation when the hospital contacted them after Resident #2 was already in the Intensive Care Unit. On 04/02/2026 at about 9:08 AM, the Director of Nursing (DON) and the Administrator reported that they were not aware of the facility policy requiring notification of the resident's representative when there is a change in status or a transfer to the hospital. The DON explained that staff typically do not notify representatives if the resident is alert, oriented, and able to make decisions. They were informed of earlier chart reviews showing that representatives were not notified during changes in status for Resident #2 and #4. On 04/01/2026, a review of the facility's Change of Condition policy (reviewed June 2025) requires the Nurse Supervisor to notify the resident's representative whenever the resident experiences an accident or incident resulting in injury, any significant change in physical, mental, or psychosocial status, a room change, a discharge, or the need for hospital transfer-unless the resident has specifically requested otherwise.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations and staff interviews, the facility failed to maintain appropriate food handling and storage practices, as numerous food items across dry storage, refrigeration, and freezer areas were found unlabeled, undated, uncovered, or unsanitary. The findings include: During a kitchen tour conducted with the Registered Dietitian Nutritionist (RDN) on 04/01/2026 at approximately 10:04 AM, multiple deficiencies in food labeling, storage, and sanitation practices were observed: In the dry storage area, two opened bags of pasta, a gallon of red wine vinegar, a gallon of apple cider vinegar, an opened bag of rice, two cartons of dried mashed potatoes, and more than thirty opened spice containers lacked labels indicating when the items were opened. In the refrigerated section, three prepared sandwiches and three prepared salads were stored without preparation or open date labels, and a box of chocolate shakes had sticky residue on the exterior surface. In the freezer, a zip locked bag of meat was stored without any label identifying the contents or dates. Canned goods on the shelving had date markings that were not easily readable, preventing staff from determining product rotation or identifying older inventory. The RDN acknowledged ongoing issues with labeling and confirmed that undated prepared foods were being discarded. The facility currently has no permanent dietary manager, and the interim manager is absent due to illness. During an interview on 04/01/2026 at approximately 3:00 PM, the Administrator acknowledged the deficiencies identified by the RDN and provided documentation of education given to dietary staff on proper food labeling and storage procedures. A review of the facility's policy titled Food Storage stated that food storage areas shall be maintained in a clean, safe, and sanitary manner.</p>		