

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Bay Village of Sarasota		STREET ADDRESS, CITY, STATE, ZIP CODE 8400 Vamo Road Sarasota, FL 34231	

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)
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>Based on observation, review of facility policy and procedures, record review and staff interviews, the facility failed to maintain a urinary catheter in a safe and sanitary manner for 1 (Resident #5) of 1 resident reviewed with an indwelling urinary catheter.</p> <p>The findings included:</p> <p>The facility policy Catheter Care documented The purpose of this procedure is to prevent urinary catheter associated complications, including urinary tract infections. Use aseptic technique when handling or manipulating the drainage system. Be sure the catheter tubing and drainage bag are kept off the floor.</p> <p>Review of the clinical record documented Resident #5 had an admitted [DATE] with diagnoses including schizophrenia, type 2 diabetes mellitus, hypertensive heart disease. The record revealed the resident was receiving hospice services.</p> <p>The record showed a physician order dated 4/13/24 instructing staff to insert an indwelling urinary catheter to promote wound healing of a pressure wound on the resident's coccyx.</p> <p>On 4/16/24 at 9:33 a.m., Resident #5 was observed in her room in bed and was noted to have an indwelling urinary catheter. The catheter drainage bag was attached to the bed frame and the bed was in the lowest position. The catheter drainage bag and tubing was in contact with the floor.</p> <p>Photographic evidence obtained.</p> <p>On 4/16/24 at 10:44 a.m., during a walking tour with the Assistant Director of Nursing (ADON) confirmed the drainage bag was on the floor and should be off the floor. The ADON attempted to readjust the drainage bag and tubing and placed a towel and under the catheter drainage bag to prevent contact with the floor.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>49527</p> <p>Based on observation, staff interviews, and record reviews, the facility failed to ensure its medication error rate remained below 5%. Five licensed nurses with 26 opportunities were observed. Two medication errors were identified resulting in a 7.69% error rate.</p> <p>The findings included:</p> <p>On 4/18/24 at 8:34 a.m., Licensed Practical Nurse (LPN) Staff Q was observed administering medications to Resident #261. LPN Staff Q administered 1 chewable 81 milligram (mg) aspirin to Resident #261. The physician's order was ordered for aspirin 81 mg delayed release.</p> <p>On 4/18/24 at 8:20 a.m., LPN Staff P was observed administering medications to Resident #23. LPN Staff P administered 1 tablet, vitamin D 25 micrograms (mcg,) for Resident #23. The physician's order was vitamin D3 25 mcg (1,000 unit) tablet, 6 tablets by mouth once daily for vitamin deficiency.</p> <p>An interview on 4/18/24 at 8:55 a.m., with LPN Staff Q, she confirmed she gave a chewable 81 mg aspirin to Resident #261 and the physician's order is aspirin 81 mg tablet, delayed release, 1 tablet by mouth once daily for cerebral infarction.</p> <p>An interview on 4/18/24 at 11:38 a.m. with LPN Staff P, she confirmed she gave 1 vitamin D 25 mcg tablet for Resident #23. LPN Staff P reviewed the order and confirmed the order is written to administer 6 tablets of vitamin D3, 25 mcg by mouth once daily.</p>

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618</p> <p>Based on observation, record review, and resident and staff interviews, the facility failed to ensure 1 (Resident #19) of 3 residents reviewed for dental services received appropriate care and services for broken teeth.</p> <p>The findings included:</p> <p>On 4/15/24 at 12:43 p.m., Resident #19 revealed she had missing upper and lower teeth. The resident said she lost several of her teeth several months ago, and because of the missing teeth, her diet was changed to mechanical soft so she could eat her food. She said she would like to eat regular food, but due to her missing teeth, she is unable to eat a regular diet.</p> <p>A review of Resident #19's medical record revealed her original admission to the facility was on 11/16/17 and a readmission on 11/5/20. The Nursing Admission assessment dated [DATE] stated Resident #19 had no broken or loosely fitting full or partial dentures, natural teeth or tooth fragments, or chewing or swallowing difficulty.</p> <p>A dietary progress note dated 10/24/22, said Resident #19 had lost three front teeth, and due to this, her diet would be changed to a mechanical soft diet/food.</p> <p>A care plan meeting progress note, dated 10/25/22, stated the meeting was attended by the facility's interdisciplinary team (IDT) and Resident #19's daughter, said Resident #19 recently lost teeth. The daughter will have to arrange an appointment with the resident's dentist and let the nursing department know the date of the dental appointment. The daughter was told transportation to the dental appointment would be at her expense.</p> <p>A dietary progress note dated 10/25/22 said Resident #19's daughter attended the care plan meeting and was aware her mother's diet was changed to a mechanical soft diet due to the loss of the three front teeth. The daughter was aware Resident #19's teeth need to be fixed.</p> <p>The care plan meeting progress note, dated 1/31/23, stated the meeting was attended by the IDT and Resident #19's daughter. The IDT wrote that Resident #19 was stable overall. The Social Worker (SW) asked the daughter if she had arranged for a funeral home in the event of Resident #19's death. The daughter said the funeral homes wanted prepayment, and she didn't have the money set aside to pay for the funeral home. She wanted any money she had for her mother's teeth replacement.</p> <p>A review of the facility's Dental Services policy noted that it was not dated. The policy stated that routine and emergency dental services were available to meet the residents' oral health needs in accordance with the resident's assessment and plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The policy said oral health services were available to meet the resident's needs, and routine and emergency dental services were provided to their resident through referral to the resident's personal dentist, community dentist, or other health care organization that provides dental services. A list of community dentists available to provide dental services would be provided to the residents and was available from Social Services. Social Services personnel were responsible for assisting the resident/family in making dental appointments and transportation arrangements as necessary.</p> <p>On 4/18/24 at 11:53 a.m., in an interview with the Social Service Director (SSD), she confirmed during the care plan meeting on 10/25/22 with the IDT and Resident #19's daughter, that Resident #19 had lost three front teeth, causing her diet to be changed to mechanical soft diet/food because of the missing teeth. She said Resident #19 was on Medicaid, and the IDT told Resident #19's daughter she was responsible for finding a dental service to fix Resident #19's broken teeth. The SSD said after reviewing Resident #19's medical record, she could not find documentation of the facility finding a dental service to fix Resident #19's broken teeth or documentation the facility had assisted Resident #19's daughter in finding dental services to fix Resident #19's broken teeth. The SSD said she would contact Resident #19's daughter to determine if Resident #19's daughter had found a dental service to fix Resident #19's broken teeth, as noted in the 10/25/22 care plan meeting.</p> <p>On 4/18/24 at 3:04 p.m., in an interview with the SSD, she said she had received an email from Resident #19's daughter stating this was a follow-up email to their previous conversation regarding Resident #19's dental care. Resident #19's daughter said she was unable to find a traveling dentist in the area, and due to her mother's physical condition, it would be a challenge to transport her to a dental office. She said the cost would be over \$20,000 to fix her mother's broken teeth. Because neither her mother nor herself can afford the dental service, and because they do not have the money, her mother has to remain on a soft diet. The email ended with Resident #19's daughter asking the SSD if she is aware of any alternatives, and the daughter would be open to any suggestions.</p> <p>The SSD said she is unable to find any documentation that she and/or anyone in the facility had assisted Resident #19's daughter in finding dental service as required in their Dental Services policy and procedure to address Resident #19's broken teeth, which were identified and noted in the 10/25/22 care plan meeting.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>49527</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, staff interviews, resident interviews, and resident council meeting notes, the facility failed to serve food that was palatable and at the appropriate temperature for 4 (Residents Resident #23, #26, #259, and #261) of 4 residents interviewed and Resident Council concerns reviewed from 1/2023 through 12/2023 for food palatability and appropriate temperature. This had the potential of decline in health due to poor nutrition.</p> <p>The findings included:</p> <p>On 4/16/24 at 12:25 p.m., Resident #26 was observed with a sandwich and pot roast stew. She said the sandwich is warm today, and the pot roast stew needs heated. Her meal ticket has a tossed salad listed and there was no salad on Resident #26's tray.</p> <p>During an interview on 4/15/24 at 2:18 p.m., Resident #26 said the food is not good. The grilled cheese is cold. The bread does not look like it is grilled, and the cheese is not melted. The bun was ice cold on a sandwich. The mac and cheese was served cold.</p> <p>During an interview on 4/15/24 at 9:30 a.m., Resident #259 stated the food is up and down. The list they gave to circle likes and dislikes are not followed. The transition has not been good. Resident #259 made a diet plan out 3 times and it was not right. His daughter went down to the kitchen and had to speak to someone to finally get it corrected.</p> <p>During an interview on 4/16/24 at 9:39 a.m., Resident #259 said requested a grilled cheese sandwich, and it was not cooked. The grilled cheese came with lima beans and roasted tomato. Resident #259 said the side choices served with grilled cheese was not an appetizing combination.</p> <p>During an interview on 4/16/24 at 12:33 p.m., Resident #259 said staff brought the wrong tray to him. The staff corrected the wrong tray. Resident #259 said the beef was pretty good today.</p> <p>During an interview on 4/15/24 at 12:36 p.m. Resident #261 said the fish for lunch stunk so bad she couldn't eat it. Last night was salmon and it was good. For breakfast she gets 2 pancakes and poached eggs. She only had toast today. She had to ask staff to get a correct breakfast.</p> <p>During an interview on 4/15/24 at 12:54 p.m., Resident #23 said she hates fish and has had fish served to her several times. It is on Resident #23's meal ticket that she dislikes fish.</p> <p>During an interview on 4/16/24 at 10:14 a.m., Resident #23 said when she gets fish, she had to ask for a different meal. Staff will bring Resident #23 a sandwich that is cold and hard. Staff was brought spaghetti with no sauce on the noodles.</p> <p>During an interview on 4/17/24 at 9:47 a.m., Resident #23 said she gets toast and 2 slices of bacon every morning. Resident #23 filled out a breakfast likes paper. There is no variety for breakfast meals. Breakfast is the same every day.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/17/24 at 12:17 p.m., with the Certified Dietary Manager (CDM), she said if a resident does not fill out breakfast likes and dislikes paper, they get scrambled eggs and pancakes every day. If they do fill out a food likes and dislikes paper, they will get their choices every day. If the resident only circles 2 items, they will get those 2 items for every breakfast.</p> <p>During an interview on 4/17/24 at 1:09 p.m. with Registered Nurse (RN) Staff R, she said the CDM comes up and talks to the residents and gives them the form to fill out for food likes and dislikes. The CDM would revisit the likes and dislikes quarterly for long term care residents.</p> <p>During an interview on 4/18/24 at 1:34 p.m. with the CDM, she said the food concerns are brought to her by staff or residents. Resident Council gives her food concerns. The CDM gets emails and has not been asked to attend resident council meetings. The CDM has only received 1 meal complaint from Resident council dated 2/2/24. The CDM said just found out Resident #23 does not like fish.</p> <p>Review of the resident council meeting minutes from 1/2023 through 12/2023 revealed the following food concerns:</p> <p>1/19/23: Residents would like a better variety of food. Sometimes the food isn't hot like it should be.</p> <p>2/8/23: Residents would like more of a selection of food and drinks. Residents would like more sauce for their side dish on the side.</p> <p>Residents are not happy with the food. Residents said by the time they get their food it is cold when it should be hot. Some of the food isn't always cooked all the way. The ice cream gets to them melted.</p> <p>3/8/23: Residents would like more of a variety of food. They would like pizza on the menu. The residents would like the meats to be easier to cut. They would like to have more sauce on their foods that need sauce. Food seems difficult to keep warm.</p> <p>4/11/23: Residents would like to have breakfast menus to fill out. The food sometimes isn't cooked all the way. The coffee is cold.</p> <p>5/9/23: Residents are saying they fill out their menus, but they don't get what they have selected.</p> <p>6/13/23: The residents would like more sauce to put on the foods that require sauce. They would like the hot food to be hot and the cold food to be cold.</p> <p>7/11/23: the residents would like more vegetarian meals. The residents would like more sauce on their food. The food isn't hot enough for the residents.</p> <p>8/3/23: Meat is tough. Tickets are not what they ordered.</p> <p>10/5/23: Not satisfied with menus-several residents agree.</p> <p>November 2023: Residents said food was often overcooked and not seasoned very well.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/2/23; Food not warm and overcooked. More sauce on spaghetti.</p> <p>12/6/23; Food is not warm when it arrives. Want more variety, hot when it's served. Beef is cooked too long.</p> <p>12/6/23: Residents stated the food is not warm when it arrives to them, and the beef is usually overcooked. Other than that, they said the food is pretty good usually.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155</p> <p>The facility failed to prepare, and store food in a sanitary manner by failing to cover and date food in 2 walk-in coolers and 1 refrigerator. The facility failed to ensure staff used the three compartment sink appropriately including use of the proper sanitizing agent. The facility failed to ensure staff wear hair restraints during preparation of food. The facility failed to service and maintain ice machines in the main dining room and three of three nourishment rooms.</p> <p>The findings included:</p> <p>1. The facility policy and procedure for Walking Cooler, documented to protect and ensure that food is free from foodborne illness, contamination, and hazards. All foods stored in coolers are labeled and dated.</p> <p>During an initial tour of the kitchen with the Certified Dietary Manager (CDM) and the Director of Dining (DOD) on [DATE] at 9:20 a.m., the following was observed:</p> <p>a.) In the line reach in refrigerator was a box of muffins without a date and sitting on top of the muffins was another box containing empty plastic cups. The observation was confirmed the CDM.</p> <p>Photographic evidence obtained.</p> <p>b.) In the walk-in cooler #1 there were two tray's with uncooked broccoli that were uncovered on pans with no date. There were 2 trays of uncovered and undated calzones on a cart. The findings were verified by the DOD.</p> <p>Photographic evidence obtained.</p> <p>c.) In the walk-in cooler #2 there was an uncovered tray of small pie shells and a tray of unknown food items that were uncooked and uncovered on trays. The tray of pie shells was resting on top of the unknown food item. There were 3 trays of an uncooked food item the DOD identified as chicken. The top tray of the chicken was sitting on top of the tray beneath it. The findings were verified by the DOD.</p> <p>Photographic evidence obtained.</p> <p>2. The facility policy Dish Machine and 3 Compartment Sink Procedures documented</p> <p>Three compartment sink operator requirements:</p> <p>a. The three-compartment sink should be drained, cleaned and refilled with fresh water/solutions after each meal period or when water becomes dirty using the 3 compartment sink instructions on the wall chart.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>b. Sanitation solution levels should be logged before each meal period. This log should be kept on the log board or filed for reference.</p> <p>The wall chart for the 3-compartment sink located above the sink, specified Sanitizer Tips:</p> <p>Test sanitizer solution in sinks and trigger sprayers often to verify 200 parts per million (PPM).</p> <p>Do not test directly from the dispenser. Fill the sink to the proper level then test from the sink.</p> <p>Be sure to use only authorized test strips.</p> <p>Do not hold the test strip in the solution for more than 1 second.</p> <p>Use only 200 PPM solution sanitizer.</p> <p>On [DATE] at 1:00 p.m., during a second tour of the kitchen in the second sink dedicated for rinsing, the pots and pans were piled and stacked above the water line and not in contact with the rinsing solution. The CDM confirmed the cooking utensils should be fully submerged in the sink.</p> <p>Photographic evidence obtained.</p> <p>The CDM was asked to test the sanitizer in the third compartment of the sink. The CDM had a bottle of test strips, took one out and dipped it into the sanitizing sink. The test strip failed to turn the green color indicated on the bottle to assure 200 PPM of sanitizing agent. The test strip failed to turn any color indicating there was no sanitizing agent in the sink.</p> <p>The CDM tested the water in the sanitizing sink for a second time with the test strip in the water for 5 seconds. The test strip remained yellow indicating no sanitizing agent. The CDM confirmed there was no sanitizing agent in the sink.</p> <p>A review of the test strip container showed an expiration date of ,d+[DATE]. The CDM said she was unaware the test strips had expired and said, we have more, I will get another bottle The CDM returned with several test strips in her hand, not in a test strip container. The CDM dipped several test strips in the sanitizing water, moving them back and forth for a few seconds. The test strips failed to identify any sanitizing agent in the sink.</p> <p>On ,d+[DATE]/ 24 at 1:15 p.m., Dishwasher Staff O removed 2 sheet pans from the rinse sink and placed them into the sanitizing sink. The pans were only partially submerged in the sink. Staff O removed the trays and placed them on the clean rack to dry.</p> <p>The CDM said she would educate Staff O on the use of the 3 compartment sink and the need for the dishes and cooking utensils to be sanitized to prevent food borne illness. Surveyor informed the CDM the sheet pans would need to be removed from the drying rack and to be cleaned and sanitized.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The CDM said the Executive Chef was responsible to provide education to the dietary staff on the use of the 3-compartment sink. The CDM said I do audits to make sure they are following instructions and I test the sanitizer solution level in the third sink. The CDM confirmed she did not keep any records of her audits of the 3-compartment sink and had no logs to indicate when the sanitizing sink was last tested .</p> <p>On [DATE] at 11:04 a.m., during a third tour of the kitchen the DOD said the dispensing line for the sanitizer in the 3-compartment sink had been clogged so no solution was being dispensed. The DOM said, we had the clogged line replaced yesterday and the sink and chemicals were all inspected. He said it was unknown when the sanitizing dispensing line had become clogged and was not dispensing the sanitizer.</p> <p>On [DATE] at 11:10 a.m., Dishwasher Staff M was observed washing cooking utensils and pots in the 3-compartment sink. The third sanitizing sink was noted to have pots and cooking utensils stacked above the water line and not submerged in the sanitizing agent. The DOD confirmed the observation.</p> <p>On at [DATE] 12:07 p.m., in an interview with the DOD said the 3-compartment sink was operating before I left for vacation and when I returned it was not functioning. I went on vacation on the [DATE] so it has been a week or so but not longer then that. I was testing the sanitizing agent before I left. He confirmed there was no way to know when the sanitizing dispenser for the sanitation sink had stopped dispensing the sanitizer. He said the staff are to check the sanitizing level in the sink several times a day and the water is changed hourly so they are supposed to check the level then. He confirmed he had no documentation he or the dietary staff were checking the sanitizer levels to ensure the dishes were sanitized.</p> <p>3. The facility Policy and Procedure for Hair Restraints and Beard Guards documented, To ensure that food is free from contamination, food service staff are required to wear protective gear. According to food safety guidelines any employee working in a food production establishment must wear a hair restraint that prevents hair from coming into contact with food products. Allowed hair restraints include hair nets, hats, beard and mustache nets and clothing that covers body hair. Food handlers with facial hair such as overgrown sideburns, mustaches and beards required protective gear.</p> <p>On [DATE] at 11:15 p.m., Chef N was observed preparing mashed potatoes and other foods. Staff N had a mustache and beard that were not covered when he was preparing the food. The DOD was present during the observation and did not instruct Staff N to cover his facial hair. There was a total of 4 male staff in the kitchen with some sort of facial hair and only 1 had a facial cover over his beard.</p> <p>4. The manufacturers guideline for the facility ice machines, Cleaning and Sanitizing Instructions documented, The appliance must be cleaned and sanitized at least twice a year. More frequent cleaning and sanitizing may be required in some condition.</p> <p>On [DATE] at 8:30 a.m., an observation of the second-floor ice machines revealed the following:</p> <p>The main dining room ice machine revealed a layer of dust and grime on the front doors of the ice machine. On the left side of the machine there was a white substance. The lower front of the machine had brown splatters of unknown origin. The inside of the ice machine had grime around the edges of the door. On the left side was a brown unknown substance.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106085	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Bay Village of Sarasota		STREET ADDRESS, CITY, STATE, ZIP CODE 8400 Vamo Road Sarasota, FL 34231	

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Photographic evidence obtained.</p> <p>In the Citrus Unit nourishment room water/ice dispenser, in the catch tray on the bottom of the machine there was a white biofilm, dust and grime. The area surrounding the dispensing spout where the water and ice comes out had a rust-colored substance.</p> <p>The findings were verified by the Assisted Director of Nursing (DON).</p> <p>Photographic evidence obtained.</p> <p>In the Magnolia Unit nourishment room, the ice machine had a white film on the front of the machine and on the spout where the ice comes out. The tray had dust and grime on the right side. The surrounding pad where the ice machine was sitting was rusted and had debris and grime. The findings were verified by Registered Nurse Staff R.</p> <p>Photographic evidence obtained.</p> <p>In the Hibiscus Unit nourishment room the ice machine had a white substance on the front of the machine and on the overflow tray. The surrounding area of the spout where the ice is released had a black substance on it. There was rust colored and brown unknown substances on the machine.</p> <p>Photographic evidence obtained.</p> <p>On [DATE] at 8:59 a.m., on a walking tour with the ADON the condition of the ice machines was verified. The ADON said Housekeeping was to clean the machines but she was not certain.</p> <p>On [DATE] at 10:00 a.m., in an interview the Director of Nursing (DON) said she had put a work order in a week or so ago to have the machines looked at. She said she was aware of the condition of the machines and would find out when they were serviced last.</p> <p>On [DATE] at 11:36 a.m., in an interview the DON she said she was not able to locate any documentation of when the ice machines were serviced. She said the dietary staff was responsible for cleaning the ice machines. She said there was no service log of who was responsible to do the cleaning and when they were to be cleaned and serviced.</p>