STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963958	10/24/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bayside Terrace	9381 U.S. Hwy 19 North Pinellas Park, FL 33782	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

List of Tags Cited:

St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0076 - 58a-5.0186 Fac - S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2013011214, was conducted on

The Bayside Terrace, assisted living facility, had deficiencies at the time of the visit.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on record review and interviews, the facility failed to honor the rights of 1 (#2) of 3 residents sampled for a

Findings include:

Record review on of resident #2's medical record revealed the resident was admitted to the facility on . Resident #2 had diagnoses of chest pain, gouty tophi of other sites, pain in knees, and aneurysm, and chronic kidney . The resident was admitted form home with hospice services and a signed by the resident and licensed physician on . Resident #2 did not wish to be and his wishes were documented with the order.

When interviewed by phone on at 11:22 a.m. staff #A stated on at 4:55 a.m. she found resident #2 sitting in his chair unresponsive. Even though the resident had hospice services, she called 911 instead of hospice and hospice was not notified until after the resident had . Staff #A stayed with the resident while staff #B went to make copies of the , demographic sheet and medication list. Staff #B did not copy the original on yellow paper as written in the facility's policies and procedures regarding . The policy stated there will be three copies of the made on legal size yellow paper and one copy will be placed in the packet, one copy placed in the resident's medical record and one copy placed behind the resident's . Staff #B handed the paperwork to Staff #A and left to handle another emergency taking place at the same time. Staff #A handed the paperwork to the staff and left to go and help with the other emergency. The personnel did not see the yellow copy of the in the paperwork and no one told them the resident had a so they started Resident #2 on the way to the hospital.

When interviewed on at 1:15 p.m., the administrator stated it was the facility's policy to make one copy of the original on yellow legal size paper just like the original and have it available for the personnel when they arrive.

Staff #B stated by phone on at 1:35 p.m. that she made the copies of the resident's paperwork but did

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not use the yellow legal size paper to copy the

personnel in an email on stated at no time were they notified the patient had a He said they were just directed to the the staff member left and they did not see her again. So seeing a patient they worked him per protocol.
He also said we had two medical emergencies going on at the same time at the facility, with two different rescue units there, so that may have explained the lack of communication.
But he said at no time were they notified the patient had a nor did he see any documentation indicating such in the paperwork given to him.

Resident #2 had his health care rights denied by improper paperwork and lack of communication to the personnel by the facility staff.

Class III

007(58A-5.0186 FAC

Based on record review and interviews, the facility failed to provide with the proper paperwork regarding a for one (#2) of three residents sampled for

Findings include:

Record review on of resident #2's medical record revealed the resident was admitted to the facility on Resident #2 had diagnoses of chest pain, gouty tophi of other sites, pain in knees, and aneurysm, and chronic kidney The resident was admitted form home with hospice services and a signed by the resident and licensed physician on

When interviewed by phone on at 11:22 a.m. staff #A stated on at 4:55 a.m. she found resident #2 sitting in his chair unresponsive. Even though the resident had hospice services, she called 911 instead of hospice and hospice was not notified until after the resident had Staff #A stayed with the resident while staff #B went to make copies of the , demographic sheet and medication list. Staff #B did not copy the original on yellow paper as written in the facility's policies and procedures regarding The policy stated there will be three copies of the made on legal size yellow paper and one copy will be placed in the packet, one copy placed in the resident's medical record and one copy placed behind the resident's Staff #B handed the paperwork to Staff #A and left to handle another emergency taking place at the same time. Staff #A handed the paperwork to the staff and left to go and help with the other emergency. The personnel did not see the yellow copy of the in the paperwork and no one told them the resident had a so they started Resident #2 on the way to the hospital.

When interviewed on at 1:15 p.m., the administrator stated it was the facility's policy to make one copy of the original on yellow legal size paper just like the original and have it available for the personnel when they arrive.

Staff #B stated by phone on at 1:35 p.m. that she made the copies of the resident's paperwork but did not use the yellow legal size paper to copy the She also stated she gave the paperwork to staff #A and then left to go and take care of another emergency.

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personnel in an email on stated at no time were they notified the patient had a . He said they were just directed to the the staff member left and they did not see her again. So seeing a patient they worked him per protocol.
He also said we had two medical emergencies going on at the same time at the facility, with two different rescue units there, so that may have explained the lack of communication.
But he said at no time were they notified the patient had a , nor did he see any documentation indicating such in the paperwork given to him.

The facility staff should have given the proper yellow copy to the personnel and stayed around long enough to inform the personnel that the resident had the so would not have been initiated. Also the facility staff should have called hospice before calling 911.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Bayside Terrace (ALF)
9381 U.S. Hwy 19 North
Pinellas Park, FL 33782

Dear Administrator:

Re: **CCR# 2013011214**

This letter reports the findings of a complaint survey that was conducted on , 2013, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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