STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943041	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Baytree Lakeside	**6411 46th Avenue North Saint Petersburg, FL 33709**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0000 - - Initial Comments
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D

Specific Tag Findings:

Assisted Living Facility

An unannounced complaint survey, CCR#2014008274, was conducted on .

The Baytree Lakeside assisted living facility had deficiencies found at the time of the visit.

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

Based on observation and interview the facility failed to ensure resident's had supplies as needed to live in a safe and sanitary environment.

Findings Include:

On . at approximately 9:20 a.m. during a tour of the residents' . it was revealed some of the resident's . did not have washcloths, hand towels, and soap available. The tour was conducted with staff # C. . 106, 109, 111,112 and 113 did not have any towels available for the residents. . 104 and 106 did not have any soap available for the residents and . 112 and 113 had broken towel racks.

Staff# C stated on . at 9:30 a.m. when the residents receive their showers the aide takes the soiled towels from the . be laundered. Staff #C did not know why the towels were not replaced or why the residents did not have soap to wash their hands.

Another tour was conducted with the administrator/owner at 11:00 a.m. on . and now the . had the towels and soap but the towel bars in . 112 and 113 were still broken and were not able to be used to hang the towels.

The administrator stated on . at 11:10 a.m. the towel racks would be repaired and soap dispensers would be refilled as needed.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943041	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Baytree Lakeside	**6411 46th Avenue North Saint Petersburg, FL 33709**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

Based on observation, interview and record review the facility failed to ensure that medications were being provided appropriately for two (# 3 and # 4) of four residents observed receiving assistance with medication during the morning medication pass.

Findings Include:

During the 9:00 a.m. medication pass on ..... staff #D was observed in the dining ..... with self administered medication. Staff #D removed the medication packet that contained all the medication Resident #3 was to take, initialed the medication observation record (MOR) as medication given before it was given and then she removed the foil covering the plastic container from the medication packet and sat the opened medication container down in front of Resident #3 with a small cup of water. Staff #D did not address Resident #3 by name, did not tell the resident what medication she was receiving and then staff #D walked away from Resident #3 before she took her medication. Staff #D did not stay to watch Resident #3 take all her pills.

Staff #D was observed getting Resident #4's medication ready without sanitizing her hands.

During the 9:00 a.m. medication pass on ..... staff #D was observed in the dining ..... with self administered medication. Staff #D removed the medication packet that contained all the medication Resident #4 was to take, initialed the medication observation record (MOR) as medication given before it was given and then she removed the foil covering the plastic container from the medication packet and sat the opened medication container down in front of Resident #4 with a small cup of water. Staff #D did not address Resident #4 by name, did not tell the resident what medication she was receiving and then staff #D walked away from Resident #4 before she took her medication. Staff #D did not stay to watch Resident #4 take all her pills.

Staff #D stated on ..... at 9:15 a.m. she did not know where the hand sanitizer was kept and she did not realize she had not told the residents what medications they were taking.
Staff #D verified she had signed the MOR before the medication was given.

The administrator/owner was interviewed on ..... at approximately 2:00 p.m. she stated staff #D would be pulled off the medication cart and sent to repeat the medication class.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Baytree Lakeside
6411 46th Avenue North
Saint Petersburg, FL 33709

RE: CCR #2014008274

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2014 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,

Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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