STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963958	05/07/2015
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Assisted Living Facility

Two complaint surveys, CCR# 2015001637 & CCR# 2015001574, were conducted on , in conjunction with a revisit to CCR# 2015001326 of .

The Bayside Terrace Assisted Living Facility had one unrelated deficiency at the time of the visit.

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on record review and interview the facility failed to ensure therapeutic diets were prepared and served as ordered by the health care provider and the facility failed to post the menu in the memory care unit.

Findings Include:

An observation on at approximately 12:00 p.m., during the resident's noon meal, revealed that the residents who had dietary restrictions and were required to receive a chopped, mechanical soft or puree diet were served a grilled pastrami sandwich for lunch.

The residents in the memory care unit did not receive a menu and were not given the opportunity to review the menu and select their lunch. The residents in the memory care unit all received the same lunch on the day of the survey.

During the tour of the memory care unit on there was no planned menu posted anywhere in the unit for the residents to review.

The Dietary Director on at 1:00 p.m. stated he did not know he had residents that required therapeutic diets and was not aware the menu was not posted.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2015001637 and CCR #2015001574

Dear Administrator:

This letter reports the findings of two complaint surveys that were conducted on . 2015 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/src
Enclosure: State (5000-3547) Form

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