STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967905	**02/01/2018**
NAME OF PROVIDER OR SUPPLIER **BAYSHORE GUEST HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **512 BAYSHORE RD** **NOKOMIS, FL 34275**	

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

0000 - Initial Comments

An unannounced biennial and limited nursing service survey was conducted on at Bayshore Guest Home, an assisted living facility (license #11852) located in Nokomis, Florida.

The following is description of the deficiencies found at the time of the visit.

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on record review, observation, and staff and resident interview, the facility failed to ensure an ongoing scheduled activities program with 12 hours of scheduled activities a week and an activity calendar posted in the common area for 6 (Resident #1, #3, #5, #6, #7 and #8) out of 6 residents capable of benefiting from structured group or individualized activities.

The findings included:

Upon entrance to the facility on at 9:30 a.m., Residents #1, #3, #5, #6, #7 and #8 were sitting in the living , in reclining chairs, facing a large screen television. The television was on and all the residents were observed to be sleeping. Resident #2 was in her cared for by a Hospice nurse and Resident #4 was in her a puzzle. Tour of the facility at this time, and again at 10:30 a.m. with caregiver Staff A present, revealed that no activities calendar was posted. Upon interview, caregiver Staff A stated, "We used to have one hanging up, but I don't know where it is."

During an interview on between 10:45 a.m. and 11:20 a.m., caregivers Staff A, B, and C, revealed that George comes to play music once or twice a month; that Resident #4 was the only resident in the facility that does puzzles and that an activities calendar had not been posted for months.

During an interview on at 1:15 p.m., caregiver Staff D, who works the 7:00 p.m. to 7:00 a.m. shift, stated, "Yes, we do puzzles, singing, and television with the residents."

On at 3:00 p.m., caregiver Staff A located the activities calendar. It was a framed erasable pen board, approximately 16 inches by 24 inches in size, labeled "Activites [Activities]" and indicating "Monday - Crafts, Tuesday - Music by George, Wednesday - Puzzles, Thursday - Coloring and Magazines, Friday - Sit & Be Fit, Saturday and Sunday's - Movie & Popcorn/Resident Choice."

During an interview on at 1:45 p.m., Resident #1's wife revealed that the only activity her husband seems to enjoy is music. Review of the activities calendar and the resident's service plan, revealed no

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indication that his activity preference had been addressed through scheduled or individualized activity.

During an observation of the facility on , from 9:30 a.m. to 5:00 p.m., no scheduled or structured activities were conducted.

During an interview on at 3:45 p.m., the Administrator acknowledged that the activities calendar had not been posted "in a month" and that no scheduled or structured activities were held in the facility on this date. She stated, "We were busy."

Class III

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

Based on record review, observation, and staff interview, the facility failed to ensure that no medication is crushed without an order for the medication to be crushed for 1 (resident #1) of 1 residents observed for medication pass.

The findings included:

Observation of Resident #1 at 1:00 p.m. on , during a medication pass observation, revealed that caregiver Staff A crushed a , medication, mixed it with applesauce, placed it on a spoon, and gave the spoon to the resident to self-administer. At 2:00 p.m., review of the physician order dated revealed no order to crush the medication.

On at 2:00 p.m., Caregiver Staff A acknowledged that there was no physician order to crush the medication.

Class III

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0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on record review, and interview, the facility failed to ensure that unlicensed staff who assistance with the self-administration of medication, recognize a medication order which requires judgment, discretion or clarification and do not administer the medication; failed to ensure that medications which require administration be administered by a licensed nurse for 1 (Resident #1) of 2 resident records reviewed for medications. The terms "judgement" and "discretion" mean interpreting vital signs and

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evaluating or assessing a resident's condition.

The findings included:

On record review of physician orders, for Resident #1, revealed an order dated for "Gel, 50mg, , , q [every] 4 hours, prn [as necessary] [for] agitation, may give one hour after routine dose if still agitated."

Review of the Medication Observation Record for 2017 and , 2018 revealed that the Gel, 50mg, , was given prn for agitation by multiple caregiver staff. In unlicensed caregivers Staff C, D and E each gave the , 1 time for agitation. In unlicensed caregiver Staff C gave the , 4 times; unlicensed caregiver Staff D gave the , 9 times; unlicensed caregiver Staff E gave the , 4 times; unlicensed caregiver Staff F gave the , 2 times, and unlicensed caregiver Staff F gave the , 1 time for a total of 20 times. Unlicensed staff are not qualified to make a judgement regarding the need for an drug to be given as needed for agitation.

During an interview on at 2:00 p.m., caregiver Staff A and the Administrator revealed that both individuals were unaware of this regulation. In addition, caregiver Staff A and the Administrator verified that caregivers had been giving this medication to Resident #1 since the prn order was written. The Administrator also stated that caregivers were giving other residents prn medications that require evaluation or assessment of a resident's condition.

Class III

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0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review, and interview, the facility failed to ensure that medications which act as chemical are evaluated annually, including justification for continued use, by the ordering physician for one (Resident #1) out of a sample of 2 residents reviewed for medications.

The findings included:

Review of the medical records for Resident #1, on , revealed that he was admitted to the facility in 2016 on , , a , medication. Review of the attending physician progress notes revealed no yearly evaluation for the continued use of this chemical .

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During an interview on at 2:00 p.m., the Administrator revealed that the physician orders for , Gel 50 mg were written on by a psychiatrist and , 50 mg by mouth were written on by a psychiatrist; not the resident's attending physician. When asked for the psychiatrist's evaluation/progress note, the Administrator stated there was none; only the orders were written.
The orders were written by an Medical Doctor (MD) whose name and phone number was listed on the top of the order sheet. Research on the Internet revealed that the MD was in a private practice for adult psychiatry in the Sarasota area.
On at 2:00 p.m., the Administrator acknowledged that additional documentation was needed.

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

Based on record review of the posted menu, observation, and staff interview, the facility failed to date the posted menu; failed to post the menu in a conspicuous manner; failed to record meal substitutions prior to or when the meal was served; and failed to provide the designated portion of protein at a lunch meal for 7 (Residents #1, #3, #4, #5, #6 #7 and #8) of 7 residents dining at noon.

The findings included:

Observation of the posted menu, on at 12:00 p.m., revealed that the menu was entitled "Week One of Four" and was not dated. Caregiver Staff C and the Administrator acknowledged that there was no date on the menu that listed Sunday through Saturday with breakfast, lunch, and dinner.

The posted menu was noted to be hanging in a corner of the dining , above wheelchair level, on an 8 inch x 10 inch paper, and had small print that was difficult to read.

The lunch meal for Thursday indicated "3 oz. seasoned chicken (protein), 1/2 cup green beans, 1 medium baked potato, 1/2 cup peaches, 1 tbsp. margarine or butter." Caregiver Staff C, who prepared the meal, verified that it was the menu being followed.

Observation of the lunch meal revealed one casserole dish used to serve 7 residents.

During an interview on at 12:30 p.m., after the meal was served, caregiver Staff C stated the

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casserole contained chicken, carrots, peas and rice. When asked if each resident received 3 ounces of chicken when served a portion of the casserole, she stated she did not weigh the chicken. Caregiver Staff C did not know how many ounces of chicken was used to prepare the casserole.

The Administrator was present at this time and said the substituted items would be recorded on the substitution list. Caregiver Staff C and the Administrator could not explain if and how each of the 7 residents received 3 oz. of protein at the lunch meal on this date.

The substitutions, used at the lunch meal on Thursday, , were observed to be recorded in the substitution log after the meal was served and eaten by the residents; rather than before or when the meal was served.

Class III

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