STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943041	R 05/15/2018
NAME OF PROVIDER OR SUPPLIER **BAYTREE LAKESIDE**	STREET ADDRESS, CITY, STATE, ZIP CODE **6411 46TH AVENUE NORTH** **SAINT PETERSBURG, FL 33709**	

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

0000 - Initial Comments

Assisted Living Facility

A revisit to a . . . . . Complaint Survey (CCR#: 2018003103, 2018002208, and 2018000692) was conducted in conjunction with a Complaint Investigation (CCR#: 2018005608 and 2018005790) at Baytree Lakeside Assisted Living Facility on . . . . . Baytree Lakeside Assisted Living Facility had deficiencies related to the revisit at the time of survey.

(License#: 6773)

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review, and interview, the Facility failed to ensure that residents' health information protected from public viewing for five Residents (#10, #19, #21, #22, and #23). The Facility failed to apply control measure to prevent abundant about of flies in dining and common areas.

Findings Included:

While conducting Facility tour, on at 07:41 a.m., medication empty bubble packs and medication container observed in, hallway, wall-mounted, mail drop off bin, labeled "Hospital Paperwork." Labels contained residents protected health information for Resident #10, Resident #19, Resident #21, Resident #22, and Resident #23.

During interview with the Assistant Administrator on . . . . . at 07:47 a.m., confirmed observation of residents' protected health information, and stated, that medication packaging were placed in the bin for medication reordering, and staff were supposed to cut or mark off resident's protected health information.

During interview with Resident #24 on at 10:08 a.m., resident complained about outdoor trash can with no lids, positioned next to exterior door nearest medication . . . . During interview, at least four flies observed resting on the resident, to include his face.

Observations of trash bins identified by the resident revealed that trash containers contained a box with . . . . . test vail with no name on labels, and medication order documentation for Resident #23. Trashcan also observed with bags of used/soiled briefs with flies actively resting on the contents of the trash can.

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On [redacted] at 10:26 a.m., the Wellness Director confirmed that observation and stated that residents' record are supposed to be shredded. The Wellness Director did not remember trash containers ever having lids, and stated that staff are supposed to throw adults briefs in the main dumpster. The Wellness directed did not know why staff were throwing residents' record, or used briefs in the trash bin located in common areas.

During meal observation, on [redacted] at 12:11 p.m., Residents observed in dining area during lunch for additional concerns with flies. The glass exterior door, located in dining area was opened. Flies observed flying in and out with no measure of entry prevention in place by the Facility. Flies observed resting on residents and residents' meal.

During interview with on at 12:15 p.m., Resident #4, Resident #17, and Resident #18 expressed concerns with amount of flies in the dining area during meals, and flies resting on the food. Residents stated that they have not mentioned concerns with flies, and were waiting for the resident council meeting to bring it up.

During interview with the Dietary Manager, on at 12:23 p.m., she stated the flies in the dining area during meals due to the dining remaining open while a third party company finished door repairs. The dietary Manager confirmed that door repairs to take multiple day to complete.

During a medication review of Resident #1 conducted on [redacted] at 07:32am, Staff B did not sanitize or provide a barrier to a table used for glucose testing before or after Resident #1.

During a medication review of Resident #4 conducted on , Staff A did not sanitize or provide a barrier to a table used for [redacted] glucose testing before or after Resident #4.

During a staff interview with the Assistant Administrator and the Director of Nursing conducted on at 01:49pm, both confirmed that Medication Technician should observe resident drawing up [redacted]. Both the Assistant Administrator and the Director of Nursing confirmed that a barrier should be placed between residents and a detergent specific for cleaning should be used between residents' [redacted] glucose testing should be used to prevent possible spread of [redacted] borne [redacted].
Class III

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

Based on observation, record review and interview, the Facility failed to observe one Resident (#) of six

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sampled residents who need assistance with self-administration of medication.

Findings Included:

During a medication review of Resident #1 conducted on at 07:32am, Staff B did not sanitize or provide a barrier to a table used for glucose testing before or after Resident #1.

During a medication review of Resident #4 conducted on , Staff A did not sanitize or provide a barrier to a table used for glucose testing before or after Resident #4. Staff A did not observe or confirm dosage amount Resident #4 dialed on the pen. Staff A did not observe Resident #4 inject .

During a medication review of Resident #5 conducted on at 08:00am, Staff A did not sanitize or provide a barrier to a table used for glucose testing before or after Resident #5. Staff A did not observe or confirm dosage amount Resident #5 dialed on the pen. Staff A did not observe Resident #5 inject . Resident #5 observed by Surveyor to dial 40 units of and inject per self. Resident #5's ordered to inject 50 units of twice every day. Staff A unable to identify how much Resident #5 injected when questioned by Surveyor. Staff did not offer Resident #5 ordered Discus 60 Inhaler. Resident #5 left medication receiving ordered Inhaler. Staff A stated that Resident #5 "keep that in her does it" per self.

During a focused record review of Resident #5 conducted on revealed that Resident #5 needs assistance with self-administration of medication.

During a staff interview with the Assistant Administrator and the Director of Nursing conducted on at 01:49pm, both confirmed that Medication Technician should observe resident drawing up . Both the Assistant Administrator and the Director of Nursing confirmed that a barrier should be placed between residents and a detergent specific for cleaning should be used between residents' glucose testing should be used to prevent possible spread of borne ,
Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation and interview, the Facility failed to (1) promptly record a change in directions for use on the medication observation record and place an alert label on the medication container that directs staff to examine the revised directions; and, (2) remove discontinued medications from the

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medication observation records for two Residents (#2 and #6) of three sampled residents.

Findings Included:

During a medication review of Resident #2 conducted on at 07:38am, revealed that two medications did not match medication observation records. The medication bottle label for Resident #2, stated, ' , DR 250mg take two tablets by mouth every day'. The medication observation record for Resident #2 stated, ' , DR 500mg take one tablet by mouth every day'. The medication bottle label for Resident #2 stated, ' 20mg take one capsule by mouth ever day'. The medication observation record for Resident #2 stated. ' 40mg take one capsule by mouth every day'. Staff C did not inform the Director of Nursing regarding the discrepancy and took no action to clarify the discrepancy.

During a medication observation records review for Resident #6 conducted on , revealed Resident #2 continues receiving , 0.05% , Solution (See Photographic Evidence4). Resident #6 medication ordered for fourteen days. Continues signed as given on current , 2018 medication observation records

During a staff interview with the Assistant Administrator and the Director of Nursing conducted on at 01:49pm, the Director of Nursing acknowledged the two medication discrepancies for Resident #2 , and medications.

Class III

0058 - Pharmacy & Dietary; Uncorrected Deficiencies - 429.42(1-2) FS; 58A-5.033(3)(a) FAC

Based on record review, observation, and interview the facility failed to ensure documented class III deficiencies regarding medicinal drugs corrected as required.

Findings Included:

During a revisit to Complaint Survey (CCR#: 2018003103, 2018002208, and 2018000692) conducted on , the Facility failed to correct a previously cited Class III deficiency previously cited (A0056).

The Facility is required to employ or contract consultant services of a licensed pharmacist or a licensed registered nurse to provide at a minimum onsite quarterly consultation until the inspection team from the agency determines that such consultation services are no longer required.

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Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observation and interview, the facility failed to ensure an outdoor deck, used by residents with and without supervision was maintained in good condition and repair.

Findings included:

During interview with Resident #19 on [redacted] at approximately 08:00 a.m., the resident expressed concerns with the condition of wooden deck, used by residents, located in the back of the property where the land meets a body of water.

Throughout the survey on [redacted], several residents were observed on the deck without staff supervision.

During an observation with the Maintenance Director on at 10:49 a.m., the deck was observed with eight loose wood panels. The Maintenance Director confirmed that the boards were loose to the point of being a safety issue for the residents with the flooring of the deck, and the loose wooden table on the deck. The Maintenance Director stated that he was not aware of the loose panels.

Class III