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	AL11963958	**10/05/2018**
NAME OF PROVIDER OR SUPPLIER **BAYSIDE TERRACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **9381 U.S. HWY 19 NORTH** **PINELLAS PARK, FL 33782**	

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0000 - Initial Comments

Assisted Living Facility

A complaint survey (CCR#2018013348 and 2018010469) was conducted on at Bayside Terrace (License #6139), an assisted living facility in Pinellas Park, Florida. There were deficiencies identified at the time of the investigation.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the Facility failed to obtain completed documentation of a medical examination (exam) by a health care provider within 60 days prior to admission or 30 days after admission for four Residents (#1, #2, #3, and #18) and the facility also failed to ensure that 2 residents (#20 and #21) had all required complete and up-to-date documentation of their face-to-face examination.

Findings Included:

A record review for Resident #1, conducted on , revealed that Resident #1's exam documentation, dated did not specify Resident #1 known . There was no height and weight documented for Resident #1. The assistance that resident #1 required for medication administration was not noted. Resident #1 was admitted to the Facility on .

A record review for Resident #2, conducted on , revealed that Resident #2's exam documentation, dated did not specify services offered or arranged by the Facility for required needs of Resident #2. According to Resident #2's exam, Resident #2 had diagnoses and history of , , Muscle , , and . Resident #2 required care and services for precautions, precautions, Physical and Occupational , and a Mechanical Soft Diet for a choking risk. Resident #2 required supervised assistance with eating and and assistance with ambulation, bathing, dressing, toileting, transferring, and medications. Resident #2 was admitted on and resided in the Facility's Memory Care Unit.

A record review for Resident #3, admitted to the facility on , revealed that Resident #3's exam documentation, dated , did not specify the required nursing services of Hospice and the Examiner's address and phone number were not provided. Resident #3's exam also did not specify services offered or arranged by the Facility for required needs of Resident #3. According to Resident

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#3's record, Resident #3 had diagnoses , , on exertion, , and . Resident #3 required Hospice Nursing services and and elopement precautions. Resident #3 also required supervised assistance with ambulation, bathing, eating, , toileting, transferring, and medications.

A record review for Resident #18, conducted on , revealed that Resident #18's exam, dated did not specify services offered or arranged by the Facility for required needs of Resident #2 . According to Resident #18's record, Resident #18 had diagnoses of , Sleep , , , and . Resident #18 required Physical , services and precautions. Resident #18 required supervised assistance with and assistance with ambulation, bathing, dressing, transferring, and medications. Resident #18 required a diet low in fat and . The Examiner's medical license number, address, phone number, and title were also not provided.

Resident record review conducted on revealed an 1823 completed on and indicated Resident #20 require medication administration.

Resident record review conducted on revealed an 1823 completed on and indicated Resident #21 require total assistance with activates of daily living (ADLs).

During an interview with the Administrator, conducted on at 05:51pm, the Administrator acknowledged and confirmed the aforementioned missing information.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the Facility failed to obtain a face-to-face medical examination (exam) after a significant change necessitated an admission to Hospice services for one Hospice Resident (#3) of one sampled Hospice Resident and also failed to ensure an interdisciplinary care plan was put in place, specifying services provided to Resident #3 by Hospice and those provided by the facility.

Findings Included:

A record review for Resident #3 who was admitted to the facility on , conducted on , revealed that Resident #3 had a decline in condition, which necessitated admission to Hospice services on . Resident #3's most recent exam documentation dated , did not specify the

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resident's Hospice service need. There was no Interdisciplinary Care Plan in Resident #3's record specifying those care and services Hospice provided and those care and services that the Facility provided. Per continued record review, Resident #3 required care and services to meet the needs for diagnoses of , on exertion, , and . Resident #3 required and elopement precautions. Resident #3 also required supervised assistance with ambulation, bathing, eating, , toileting, transferring, and medications.

During an interview with the Administrator, conducted on at 05:51pm, the Administrator acknowledged and confirmed that the Facility did not obtain an updated exam when Resident #3 was admitted to Hospice services. The administrator also confirmed that the Facility failed to obtain an Interdisciplinary Care Plan for Resident #3, which specified those care, and services provided by Hospice and those provided by the Facility.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, record review, and interview, the Facility failed to provide care, services, and supervision appropriate to the needs of nine Residents (#1, #3, #6, #9, #14, #15, #17, #20, and #21) of thirty-four sampled residents accepted for admission to the Facility.

Findings Included:

A review of the Facility's Incident Report Policy and Procedure, conducted on , revealed that, "all incidents will be reported on the Community's Incident Report form within 24-hours of the incident ...incidents include: , violation of RS Rights, and , or any other incident of concern ... [and] documentation of the incident in the resident's chart." The Incident Report Policy and Procedures also stated that the Facility would conduct and assessment after each and that the resident's Service Plan would be updated to included interventions.

A record review for Resident #1, conducted on , revealed that Resident #1 sustained two (and) and, there were no incident reports documented for these and the Facility did not update Resident #1's Service Plan or place the resident information on the facility's Tracking Tool. Resident #1 had a , which resulted in a transfer to an Acute Care Facility on . Resident #1 had no documentation that the Facility notified Resident #1's Guardian and the Facility did not follow their Incident Report Policy & Procedure for documenting the incident in Resident #1 record. Resident #1 then returned to the Facility on prescribed medications that Resident #1 had documented

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known to. Per record review, the Pharmacy notified the Facility on . The Facility failed to notify the Physician until and failed to follow-up with the Physician after no response.

A record review for Resident #3, conducted on , revealed that Resident #3 had on , , , and . There were no updated Service Plans in Resident #3's record to specify intervention put in place to reduce Resident #3's occurrences.

Review of the facility's policy and procedure titled "Adult Beverage Policy" with a revision date of revealed "Residents must maintain their personal in their apartments or a secure location as in a cabinet where it is not accessible to other residents"

Observation of was conducted on beginning at 2:23pm. There was in (two bottles of beverages on a side table in the). There were no residents in the the door to the ajar and unlocked.

Record review of the facility's census revealed Resident #20 and Resident #21 resided in . Further review of Resident #20's health assessment revealed the resident had a diet order of mechanical soft and nectar thick liquids.

Interview with the Administrator conducted on beginning at 5:15pm revealed the Administrator was aware of the beverages in and could not confirm who the beverages belonged to.

Class III

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

Based on observations, record reviews, and interviews, the Facility failed to honor resident rights by failing to provide a safe, clean, and decent living environment for all residents residing in the Facility and failed to honor the rights of one resident (Resident #1) and their guardian to make decisions regarding visitors.

Findings Included:

An observation of the Facility's grounds, conducted on at 02:19pm, revealed the following: Near the employee smoking area was a large container (labeled Cooking Oil) that had a black oil substance down the front side of the container and puddle on the ground in front of the container. Next

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to the large Cooking Oil container was a shed that contained stored insecticide and propane together. The shed and the large container did not have a locking mechanism. The area was accessible to residents, staff, and visitors/guests (See Photographic Evidence1).

During an interview with the Maintenance Director, conducted on at 03:15pm, the Maintenance Director stated that the oil container "usually has a lock on it and I'll put another one back on [and] we will move the propane tanks and insecticide from the shed and put a lock on it."

During a tour of resident with the Administrator, conducted on from 03:27pm through 04:01pm, observed the following:

- At 03:27pm, vacant found to have remnants of heavily stained carpeting;

- At 03:30pm, Resident #6 had three large portable tank not in a secured rack or holder and had feces spread all over toilet seat. The Administrator agreed that the stored unsafely.

- At 03:32pm, Resident #9 had water on the floor around the wheel chair Resident #9 was sitting in. The , floor, and baseboards were filthy. There was a soiled brief in the trashcan. The trim and baseboard broken away with missing sections (See Photographic Evidence3).

- At 03:38pm, Resident #11 and #19's drip stains on the , cabinet, walls, and toilet tank. The baseboards were filthy and the paint peeling away with dirty scuff marks on the walls (See Photographic Evidence4).
- Resident #13's heavy stains and/or soiled carpeting.
- At 03:39pm, Resident #14's entry door had a sign that stated that the housekeeper was in at 12:30pm and cleaned. However, the , toilet, sink, light switch plated were filthy (See Photographic Evidence5).

- At 03:38pm, Resident #15 entry door had a sign that stated that the housekeeper was in at 11:50am and cleaned. There was a foul smell in the resident's , the , sink and faucet, counter, toilet, shower, floors, and baseboard all filthy. Laundry in piles on the floor (See Photographic Evidence6).
- At 04:01pm, Resident #17 entry door had a sign that stated that the housekeeper was in at 12:05pm and cleaned. The , sink, mirror, counter, toilet, floor, baseboards, and shower were filthy (See Photographic Evidence7). There were multiple holes in Resident #17's and doors. The Administrator stated that the resident runs in to them with the electric wheel chair.

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During the , the Administrator stated that the daily duties of housekeepers was to sweep/mop the floors, empty the garbage, and clean the . The Administrator agreed that the resident observed did not have daily cleaning provided.

A record review for Resident #1, conducted on , revealed that Resident #1's Court Appointed Guardian requested a restriction of visitors (for the resident's safety) upon move-in . The notice stated (in all capital letters), "NO FAMILY MEMERS ARE ALLOWED INFO OR VISITATION."

A review of the Facility's Sign-in/out Log for Resident #1, conducted on , revealed that the Facility did not honor Resident #1's Guardian's visitor restriction request. Resident #1 had multiple family visitors that were restricted by Resident #1's Guardian while residing in the Facility . The visitations took place on the following dates and times (See Photographic Evidence2):

- at 06:30pm
- at 11:08am and 11:22am
- at 02:00pm
- at 05:38pm
- at 02:18pm
- at 05:25pm
- at 03:50pm
- at 11:45am
- at 01:03pm
- at 05:25pm
- at 10:37am and,
- at 01:07pm

During an interview with the Administrator, conducted on at 05:51pm, the Administrator acknowledged and confirmed that the Facility's Sign-in/out Log had documented restricted family visitors for Resident #1.

Class III

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

Based on record review and interview, the Facility failed to follow physician's order of medication for one Resident (#1) of seven sampled residents.

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Findings Included:

A review of and 2018 Medication Observation Records (MORs) for Resident #1, conducted on , revealed that Resident #1 prescribed Co- Q-10 100mg, 75mcg, ER 28mg, Silver Sulfa Cream 1%, and 1000mcg. No documentation found on Resident #1's MORs that Resident #1 received any of the aforementioned medications for any date and time prescribed for 2018. Resident # 1 had a known to Sulfa and there was only one documented attempt to notify the Physician of the ordered Silver Sulfa Cream. Resident #1 MORs did not have documentation that Resident received the prescribed medication, Co- Q-10 100mg on at 08:00am and at 04:00pm. Resident #1 MORs had documentation that Resident #1 received the medication, Silver Sulfa Cream 1% on at 08:00am & 04:00pm; at 08:00am & 04:00pm; at 08:00am; at 04:00pm; at 08:00am & 04:00pm; and, at 08:00am. Resident #1 had a known to Sulfa. Resident #1 Agency for Health Care Administration Form 1823 (1823) dated did not specify Resident #1 required assistance for medication administration and did not stated Resident #1 . On , the Pharmacy contacted the Facility regarding Resident #1 to and Sulfa. Resident #1 prescribed both medication during a Hospital visit on . The Facility did not attempt to notify Resident #1 Physician until . There was no further attempts to notify the Physician documented in Resident #1 record.

During an interview with the Administrator, conducted on at 05:51pm, the Administrator acknowledged and confirmed the lack of documentation on Resident # MORs and provided no explanation. The Administrator stated that the reason the former Director of Nursing was let go from the facility was due to failure to perform assigned duties..
Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interviews, the facility failed to ensure there was evidence of freedom from ( ) documented on an annual basis for 1 (Staff B) out of 4 employee records sampled.

Findings Included:

Employee record review of Staff B revealed a date of hire of 11/ . Staff B had a exam dated . Upon further review, there was no evidence of an updated annual examination.

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An interview was conducted with the Administrator on . . . . . beginning at 3:06pm. The Administrator confirmed that Staff B was a current employee for the facility.

On . . . . . at 6:30pm, the Administrator reviewed Staff B's employee record and confirmed there was not an annual negative exam documented in the file.

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2-3) FAC

Based on record review and interview, the facility failed to ensure that 1 of 4 employee records reviewed (Staff B) received the required incident report training.

Findings Included:

Employee record review of Staff B revealed a date of hire of 11/ and missing proof of incident reporting training.

An interview was conducted with the Administrator on . . . . . beginning 6:30pm. The Administrator confirmed Staff B was missing incident reporting training.

Class III

0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on record review and interviews, the facility maintains a secure unit and failed to ensure that 1 of 4 employee records sampled (Staff B) received . . . . . and Related . . . . . (ADRD) training.

Findings Included:

Employee record review of Staff B revealed a date of hire of 11/ , works in the memory care unit and did not have Level I or Level II of ADRD training.

An interview was conducted with the Administrator on . . . . . at 6:30pm. The Administrator confirmed Staff B was missing ADRD
Level I and Level II training.

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Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview, the Facility failed to file an Adverse Incident Report with the Agency for Health Care Administration for one Resident (#1) who had a which resulted in the transfer to an Acute Care Facility due to the resident's .

Findings Included:

A review of the Facility's Incident Report Policy and Procedure, conducted on , revealed that, "all incidents will be reported on the Community's Incident Report form within 24-hours of the incident ...incidents include: , violation of RS Rights, and , or any other incident of concern ... [and] documentation of the incident in the resident's chart." The Incident Report Policy and Procedures also stated that the Facility would conduct and assessment after each and that the resident's Service Plan would be updated to included interventions.

A Hospital record review for Resident #1, conducted on , revealed that Resident #1 sustained an unwitnessed on , which resulted in a head injury and transfer of Resident #1 to an Acute Care Facility for treatment. The Hospital had no contact information documented for Resident #1's Guardian.

A record review for Resident #1, conducted on , revealed minimal documentation in Resident #1 record related to two that occurred on and . Resident #1 most recent Agency for Health Care Administration Form 1823 (1823) dated stated that Resident #1 had a diagnosis of and short-term memory , and no mention of risk. On page five of Resident #1 1823, there were no services listed offered or provided by the Facility for or reduction. Resident #1 Progress Note dated stated that Resident #1 had "a [and] overnight." There was no follow-up documented in Resident #1 record for intervention/prevention, notification made regarding the , or an updated service plan to include . Resident #1 Progress Notes dated stated that resident #1 "was sent out to [the] Hospital." There were no reasons for the transfer and no notifications of transfer documented in Resident #1 record. Resident #1 Service Plan was not updated according to the Facility's Policy and Procedure for either . There were no risk assessments or interventions documented in Resident #1's record.

During an interview with the Administrator, conducted on at 10:40am, the Administrator denied having an incident report for Resident #1's occurrence. A later interview at 05:00pm, the

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Administrator stated that the Facility did not fill out an incident report for Resident #1.

Class III