STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11943041	01/22/2019
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 Biennial licensure survey with Extended Congregate Care (ECC) was conducted on , in conjunction with a Complaint investigation (CCR# # 2018016280).

The Baytree Lakeside, Assisted Living Facility (License #6773), had deficiencies at the time of this visit.

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, record review and interview the facility failed to assist with self-administration of medications according to requirements in 429.256 FS for one Resident (#14) of one sampled residents.

Findings Included:

During a medication pass observation conducted on at 12:22 pm, Staff H, an unlicensed staff, was observed dialing Resident's #14 , to the prescribed dose and putting a clean needle on the pen then handed the pen to resident for self injection,

A record review of the facility's training manual provided to unlicensed staff was conducted on and revealed the following instructions.

Assisting the resident with :
10. Take the pen cap off, open a new needle and attach the needle to the top of the pen.
12. Dial the prescribed dose using the dial or dosage knob at the base of the pen. Check the pen's manufacturer instructions if you accidentally dial the incorrect amount of , since each pen mechanism works differently to correcting the inaccurate dose.
15. the , to the resident for self-injection.

During an interview with staff H conducted on at 12:30 pm they stated that they dialed the dosage on the , and put the needle on the pen for Resident #14 because the resident stated they couldn't see the numbers on the pen or to put the needle on.

During an interview with the Director of Nursing (DON) conducted on at 1:30 PM they stated that the last training class taught at the facility instructed the unlicensed staff to dial the correct dosage on the , apply the needle and the pen to the resident for self-injection.

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Class III

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

Based on record review and interview, the facility failed to ensure that 3 of 4 Resident Care staff reviewed (Staff B, Staff C, and Staff E) received 3 hours of in-service training within 30 days of employment that covered resident behavior and needs and providing assistance with the activities of daily living.

Findings included:

Employee Record reviews conducted at the facility on beginning at 10:00am revealed the following:

Staff B was hired on as a Resident Aide to provide direct care to residents and was not a licensed nurse, Certified Nursing Assistant (CNA), or home health aide. Staff B's file contained a certificate for one hour training on in resident behavior and needs and providing assistance with the activities of daily living (photographic evidence obtained).

Staff C was hired on as a Resident Aide to provide direct care to residents and is not a licensed nurse, CNA, or home health aide. Staff C's file contained a certificate for one hour training on in resident behavior and needs and providing assistance with the activities of daily living (photographic evidence obtained).

Staff E was hired on as a Resident Aide to provide direct care to residents and is not a licensed nurse, CNA, or home health aide. Staff E's file contained a certificate for one hour training on in resident behavior and needs and providing assistance with the activities of daily living (photographic evidence obtained).

On at 5:15pm, the Administrator and Assistant Administrator acknowledged that training certificates only documented 1 hour of training in resident behavior and needs and providing assistance with the activities of daily living.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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0086 - Training - ADRD - 58A-5.0191(10) FAC

Based on record review and interview, the facility failed to ensure that 3 of 3 Resident Care staff reviewed (Staff A, Staff B, and Staff C) have completed 4 hours of initial training in 's or related (ADRD I) within 3 months of employment and that 1 of 1 Resident Care staff reviewed (Staff B) due for an additional 4 hours of training, entitled " and Related Level II Training," has completed the additional training within 9 months of employment.

Findings included:

Surveyor review on of the Facility's Profile on FloridaHealthFinder.gov revealed that the facility advertises provision of special care for persons with 's or related : "Special Programs and Services: Memory Care." Record reviews and interviews with residents, family members, and staff at the facility on confirmed provision of services for residents with 's or related .

Employee Record reviews conducted at the facility on beginning at 10:00am revealed the following:

Staff A was hired on as a Resident Aide to provide direct care to residents. Staff A's file contained a certificate for 2 hours training in " and Related " "awarded" by by an RN (Registered Nurse) (photographic evidence obtained). Staff A's file did not contain evidence of 4 hours of initial training in 's or related (ADRD I) within 3 months of employment (due by).

Staff B was hired on as a Resident Aide to provide direct care to residents. Staff B's file contained a certificate for 2 hours training in "Home Health Care and Related ." by an RN (Registered Nurse) dated (photographic evidence obtained). Staff B's file did not contain evidence of 4 hours of initial training in 's or related (ADRD I) within 3 months of employment (due by), and Staff B's file did not contain evidence of 4 hours of additional training in 's or related (ADRD II) within 9 months of employment (due by).

Staff C was hired on as a Resident Aide to provide direct care to residents. Staff C's file contained a certificate for 2 hours training in " and Related " "awarded" by by an RN (Registered Nurse) (photographic evidence obtained). Staff C's file did not contain evidence of 4 hours of initial training in 's or related (ADRD I) within 3 months of

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employment (due by).

On at 5:20pm, the Administrator and Assistant Administrator observed the 2-hour training certificates and agreed that since the facility serves residents with 's or related , Resident Aides need to take the initial 4-hour training and will need to take the additional 4-hour training within 9 months of employment, acknowledging that Staff B is overdue for completion of both ADRD I & II.

Class III