Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963958	A. BUILDING: _____ B. WING _____	06/28/2019

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

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A 000	Initial Comments A complaint investigation (complaint number 2019009838) was conducted from 06/25/2019 until 06/28/2019 at Bayside Terrace Assisted Living Facility. There were deficiencies identified at the time of survey.	A 000		
A 025 SS=J	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel	A 025		

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A 025	Continued From page 1 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to provide care and services appropriate to meet the needs, supervision, daily observation and general awareness of the health, safety and physical well-being of residents for 9 (#1, #2, #3, #4, #5, #6, #7, #8 and #10) of 14 residents sampled that had illnesses, required [redacted] and health care concerns, in a building identified with heat related concerns. Additionally, the facility failed to provide [redacted] care to meet the needs of 2 residents (#11 and #12) of 2 residents sampled that received [redacted] care. Findings Included: An interview was conducted with Staff G on 6/26/19 at 8:00 p.m.. Staff G disclosed a resident of the facility (Resident #1) and whose family member still lived in the facility, was sent to the hospital about a month prior and was put on a [redacted] in the [redacted] of the hospital. Staff G stated Resident #1 had been living in a room of the facility where the temperature was	A 025		

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A 025	Continued From page 2 very hot. An interview was conducted with Resident #20 at 11:47 am on /19. Resident #20 stated he shared a room with a family member (Resident #1). Resident #20 stated the room shared with Resident #1 was "very hot" and the air conditioner did not work, prior to the hospitalization and of Resident #1. A closed review of Resident #1's records revealed he had a history of , , and a , but that the resident was taking medications to control health issues and was able to perform all activities of daily living (ADLs) independently without assistance. Resident #1's face to face health assessment performed by a physician (AHCA form 1823) dated /18 revealed the resident had no special precautions, did not need any nursing, treatment or , , services and that the resident's cognition was "appropriate" (photographic evidence obtained). A review of Resident #1's hospital records on /2019 (photographic evidence obtained) revealed, Resident#1 arrived to a local hospital on /19 around 5:00 p.m. with chief complaint "patient , air conditioning (A/C) has been out in (patient's) apartment." Oral temperature upon arrival was 102.9?. The "history of present illness" portion of the record revealed that Resident #1 was not eating, had and and the onset of the illness was 5 days ago (approximately /2019). The course/duration of condition stated to be "constant and worsening". Resident #1 was sent to the Critical Care Unit for treatment of , (skin warm, system, , , system), , , and , , requiring and mechanical supervision. The resident was	A 025		

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A 025	Continued From page 3 admitted to the . . . . . (. .). Resident #1 was transferred to the hospital's in-patient hospice unit on . . . . /2019. An observation of Resident #2 on . . /19 at 3:40 p.m., in the common area of the 2nd floor of the facility, revealed the resident sitting in a chair, her shaking and complaining of not feeling well because of the heat. The temperature in the room, at the time, read 88.5?, as read from the thermometer on the portable A/C unit. Resident #2 stated that her tremors were worsening and her . . . appeared to be flushed, the skin around her , was bright pink. AHCA requested the Regional Nurse to take the Resident #2's vital signs and call 911. At 3:45 p.m., the Regional Nurse took Resident #2's , and got a reading at . No other vital signs were taken. The Regional Nurse stated the facility did not have a thermometer to take the resident's temperature. At 3:50 p.m., Resident #2 stated she had not slept well the night before. The non-emergency paramedics arrived at the facility at 4:05 p.m.. The paramedic observed Resident #2 and stated that the facility had called the non-emergency paramedics and they could not help the resident, and that the facility should have called for an ambulance. A paramedic on the scene then called for an ambulance. While waiting for the ambulance to arrive, a paramedic took the resident's . . . . , and got a reading of (high). A paramedic stated that the resident's condition (appeared to be) affected by heat and stated "it can't help with a bad A/C." A paramedic placed a monitor on the resident and, after reviewing the reading, said of Resident #2's . . condition, "your is not very happy right now". The ambulance arrived at 4:10 p.m. and took the resident to the hospital.	A 025		

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A 025	Continued From page 4 Hospital records dated /19 for Resident #2 were reviewed on /19 (photographic evidence obtained). The records revealed the resident's was elevated and she was brought to emergency department for further evaluation. The resident was to return back to the facility, however the facility told the hospital that the A/C was currently not working and it was not safe for Resident #2 to return to the facility. Subsequently, Resident #2 was admitted to the hospital pending a safe place to be discharged. In an interview with Resident #3 on /19 at 1:32 p.m., Resident #3 stated that on /19 and /19 the temperature in his apartment was 85 degrees and it made him feel terrible. Resident #3 stated he required daily and was not able to breath on /2019 when the facility's A/C and electricity went out. Resident #3 stated, "When you say to staff hey! I can't breathe, I have no , and someone just says "ok" and leaves and never comes back to help, that's the most frightening feeling ever." He said, "I felt like jumping out of the window because of the heat." A review of Resident #3's records, on /19, revealed that the resident has a history of , , and (of the and). The face to face assessment by a physician (AHCA for 1823) was undated but revealed that the resident required , as needed, to maintain a saturation of more than 93%. During a tour of the facility on 6/26/19 at 10:15 a.m., accompanied by the Administrator, Resident #4 was heard asking the Administrator if anyone in the facility knew how to use the tanks	A 025		

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A 025	Continued From page 5	A 025		

he had in his room, because he did not know how to use them. The Administrator called out in the hallway and asked if someone could please get a home health agency representative to come visit Resident #4 to evaluate whether the resident required assistance with tanks and . Resident #4 stated he was uncomfortable because of the heat and the thermostat in the room read 80 degrees.

A record review for Resident #4 was conducted on 7/1/19 and revealed he was admitted to facility on /19 with a history of , ( ) and he was dependent on . Progress Notes from the resident's physician, dated /19, stated that home health services were needed, based on medical need, for improving home safety. Skilled nursing, , and , were needed to evaluate and treat with transition into the new environment (of the facility), safety awareness, medication management and education, increasing balance and coordination, and the reduction of possible environmental hazards. The facility failed to schedule the ordered home health services, based on the resident's room having unsafe storage of tanks and the resident requesting help with using the tanks.

On /19 at 12:45 p.m., during an interview with Resident #5, the resident stated that the facility lost power on /19 at 4:00 a.m.. At the time, the resident felt extremely overheated, drained, and was without ( ) for over almost an hour and could not breathe. Resident #5 was observed wearing a connected to an concentrator (which requires electrical power) for .

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A 025	Continued From page 6 During an interview with Resident #6 conducted on /19 at 12:58 PM, she stated, "Yes I was hot indeed. Monday night was the worst night of my life, it was so hot inside this room and I felt terrible." She said she had been sleeping all day and that she had no energy. Resident#6 stated, she requires because she has a hard time breathing and being exposed to scorching temperature made it difficult for her to breathe. Resident #6 recalled her room temperatures as 85 degrees and above on . Resident #6 was observed wearing a connected to an concentrator (which requires electrical power) for . A record review of the facility's roster of residents receiving hospice services and on /19 revealed that Resident #7 was a hospice patient and received . An observation of Resident #7's room on /19 at 3:50 p.m. revealed the resident wore a connected to an concentrator (which requires electrical power). There were no portable tanks in the room, should a power outage occur. A record review of the facility's roster of residents receiving hospice services and on revealed Resident #8 was a hospice patient and received . An observation in the room of Resident #8 on at 3:40 p.m. revealed the resident wore a connected to an concentrator (which requires electrical power). There were no portable tanks in the room, should a power outage occur. During an interview with the Administrator conducted on 6/27/19 at 6:39 p.m., the Administrator stated she had no idea which residents required or had access	A 025		

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A 025	Continued From page 7 to portable , , tanks, if needed, during an outage. The Administrator did not know if any residents went without their required , , , , during that extended time of the power outage and she confirmed the residents were exposed to extreme heated temperatures above 86 degrees since /2019. Resident #10 was observed in the resident's room at 6:50 p.m. on /19. Resident #10 was lying in bed, sweating, and stated the resident did not feel well, that it may be the . The room thermostat read 80? at the time. Staff H went to inform the nurse on duty about Resident #10 not feeling well. The nurse on duty, the Regional Nurse, came into Resident #10's room at 6:55 p.m. and took resident's , and offered hydration. The Regional Nurse stated the facility did not have a thermometer to take any of the resident's temperature for vital signs, the nurse stated, "We don't do that here." During observations of Residents #11 and #12, conducted on /19 at 1:05 p.m., Staff A entered the Memory Care Unit with the Surveyor. Staff A responded to Resident #12 who had feces down the resident's left pant . Staff A pulled Resident #12's pants down on the right side exposing the resident's soiled brief while the resident was in the hallway. Staff A pulled Resident #12's pants back up and walked away. Resident #12 paced up and down the Memory Care Unit's hallway where other residents were gathered near the television room. Staff A went in to the dining room where other staff were at. Resident #12 continued pacing up and down the hallway past Staff B and another staff (name unknown). Resident #12's roommate, Resident #11 was observed lying in bed on the resident's left side facing away from the open	A 025		

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A 025	Continued From page 8	A 025		

door. Resident #11 had no pants, brief, or sheet covering the resident's exposed , and . . . . . The bottoms of Resident #11's . . . (right and left) were covered in a dried black substance consistent with and smelled like feces (See Photographic Evidence 1). At 01:30 p.m., the Surveyor left the Memory Care Unit and staff never attended to Residents #11 or #12's . . . . . care needs. At 02:00 p.m., the Surveyor returned to the Memory Care Unit and observed Resident #11 lying in bed in same position as previously described and continued with exposed naked lower body with the room door open. Resident #11's (right and left) continued with dried feces on the bottoms. At 03:00 p.m., the Surveyor returned to the Memory Care Unit and observed Resident #11 lying in bed in same position as previously described and continued with the resident's exposed naked lower body with the room door open. Resident #11's . . . (right and left) continued with dried feces on the bottoms.

A record review for Resident #11, conducted on 06/28/19, revealed that Resident #11 had a Health Assessment Form dated /17, which stated that the resident had a diagnosis of and required assistance with activities of daily living for bathing, grooming, dressing, and toileting.

A record review for Resident #12, conducted on 06/28/19, revealed that Resident #12 had a Health Assessment Form dated /19, which stated that the resident had a diagnosis of and required supervision with activities of daily living for ambulation, bathing, dressing, eating, grooming, toileting, and transferring.

During an interview with the Administrator,

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A 025	Continued From page 9 conducted on 06/28/19 at 03:40 p.m., the Administrator stated that it was expected of care staff to change residents' . . . . . immediately and stated "no" when asked if twenty-five minutes was considered immediate attention. The Administrator stated, "I am taking care of that right now" and left the room when the Surveyor showed the Administrator Photographic Evidence with Resident #11's . . . covered in dried feces. The Surveyor explained the timeframe of Resident #11's . . . bottoms being left covered in feces and that both Staff A and B disregarded Resident #12's . . . . . care need. Class I	A 025		
A 077 SS=J	429.176 FS; 429.52(4-5),58A-5.019(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52(4-5), FS (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator	A 077		

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A 077	Continued From page 10 to an administrative fine as prescribed in s. 429.19. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 58A-5.019 Staffing Standards. (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by Part II, Chapter 408, F.S., Part I, Chapter 429, F.S., Rule Chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least 21 years of age; 2. If employed on or after October 30, 1995, have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to Sections 408.809 and 429.174, F.S.; and 4. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C., no later than 90 days after becoming employed as a facility administrator. Individuals who have successfully completed these requirements before December 1, 2014, are not required to take either the 40 hour core training or test unless specified elsewhere in this rule. Administrators who attended core training prior to July 1, 1997, are not required to take the competency test unless specified elsewhere in this rule. 5. Satisfy the continuing education requirements pursuant to Rule 58A-5.0191, F.A.C. Administrators who are not in compliance with	A 077		

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A 077	Continued From page 11 these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the death of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraphs (1)(a)4. of this rule to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to Rule 58A-5.0191, F.A.C.; and 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile radius of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements of an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to July 1, 1997, are not required to take the competency	A 077		

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A 077	Continued From page 12 test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not simultaneously serve as an administrator of any other facility. (e) Pursuant to Section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, May 2013, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04002. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation the facility failed to have an Administrator who was actively involved in providing supervision and responsible for the maintenance and operation of the facility to ensure safe temperatures were maintained throughout the facility and had an awareness of their emergency management plan during an emergent event. Additionally, the Administrator failed to follow their "emergency air plan" they initiated, which threatened the health of residents with health needs. Findings included: During a tour of the facility on 6/25/19 at 2:00 PM residents were observed sitting in their apartments with the doors closed, no fans or water (hydration) were observed and their	A 077		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 077	Continued From page 13 windows were closed. Temperatures taken during the tour using a thermo-hygrometer showed readings of 84 degrees and above in multiple resident rooms and main common areas. During an interview with the Administrator on 6/25/19 at 4:00 PM the Administrator acknowledged there were resident rooms and main common areas with temperatures above 86 degrees. She stated the first floor was cooled down and staff were encouraging the residents to relocate to the first floor. On 6/25/19 after 4:00 PM no residents were observed being relocated to the first floor or to rooms with appropriate (81 degrees and below) temperatures. On 6/25/19 the facility rented chillers to cool down the resident rooms and main common areas, although they failed to provide the required maintenance of emptying the condensation to prevent them from shutting off. During tours of the facility on 6/26/19, 6/27/19 and 6/28/19 chillers were observed to not be operating due to non-maintenance, resulting in these areas rising above 81 degrees. On 6/25/19 at approximately 8:00 PM the agency requested the Administrator to provide an emergency air plan to ensure the safety of the residents during the emergent event. On 6/25/19 at 10:00 PM the Administrator provided a copy of a "plan for emergency air" to the agency. (see below) 1. Portable AC units have been placed in the 13 units on 3rd floor, 7 units on 2nd floor and 2 units in the 1st floor that temperatures remain above 80	A 077		

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	AL11963958	A. BUILDING: _____ B. WING _____	06/28/2019

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A 077	Continued From page 14 degrees. 2. These units will be checked every 2 hours to ensure they maintain less than 80 degrees. 3. The portable AC units will generate condensation and the water tanks will fill and need to be emptied. 4. The ED and Memory Care Director will remain in the building throughout the night and empty the water in order to ensure that the portable AC units remain working and cooling the units. 5. In the event that the portable AC units fail to keep the units below 80 degrees the residents will be moved to the dining room and living room on the first floor until arrangements can be made to evacuate them to a sister community. 6. Evacuation proceedings will begin within 4 hours of relocating the residents from their units to the dining room or cooler area in the building. 7. If evacuation is needed - the community will follow the evacuation procedures as outlined in the CEMP approved by Pinellas County 9/1/18. On 6/26/19 the facility purchased 22 window air conditioner (A/C) units to install in resident rooms that exceeded 80 degrees. Although, during an interview with the maintenance director on 6/27/19 at approximately 9:15 AM he stated they could not install all 22 window A/C units due to an overload of electricity tripping the breaker and ultimately shutting the power off in the facility. During a phone interview with the Administrator on 6/27/19 at approximately 10:00 AM she stated she had a spreadsheet documenting that staff conducted resident checks every 2 hours but "could not find it." On 6/27/19 at approximately 9:30 AM the Administrator provided documentation of the resident 2-hour checks beginning on the second	A 077		

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A 077	Continued From page 15 shift of ...../19. The Administrator had no documentation to confirm 2 -hour checks were conducted on ...../19 through 3 PM on ...../19. During a review of the resident 2-hour checklist on /19 it revealed multiple resident room temperatures were above 80 degrees, with some rising to 90 degrees and the residents were not relocated. During a survey conducted on 6/25/19-6/28/19 the facility failed to evacuate any residents within 4 hours of relocation to cooler areas in the building. During an interview with the Administrator on 6/25/19 at 4:00 PM she stated she did not have a copy of the facility Emergency Management Plan (CEMP), corporate had it. When asked questions regarding the facility CEMP she was unaware of the facility evacuation plan. She stated she had not trained her staff on the emergency procedures. On 6/27/19 at approximately 4:00 PM the Administrator provided the Agency via fax with the following update. Although, through observations, interviews and record reviews the plan was not being followed. (as noted below) 1. Purchased 22 window AC units and installed them in rooms that were at 81 degrees or over to bring the room down to below 80. 2. There were 2 residents that were relocated from their apartments due to the temperature not lowering at a fast-enough rate. They were moved to units that were 77 degrees or lower. Both of those residents were moved back to their rooms by 10:30 a.m. on 6/27/19 due because the temperatures in their rooms dropped below 80 degrees and maintained that temperature.	A 077		

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A 077	Continued From page 16 3. Generator install and switch over was completed at roughly 2:30 a.m. on 6/27/19. Once completed the building was able to stabilize and the AC units that were going in and out due to the surges related to the generator install came back on and began to work as normal. 4. 2-hour room checks continued through the night on 6/26/19 and are continuing as of the time of this update (June 27, 2019 at 3:46 p.m.). Room temperatures are maintaining below 80 degrees in the units. If the temperature goes over 81 the resident will be located to another unit until their unit can be brought down the appropriate temperature. 5. The facility has rented the portable AC units until July 2nd in case they are needed. The ones not in use will be stored. If they are needed they will used. 6. The window AC units that were purchased will be used in the rooms that they are needed until the main air handler in the unit is fixed and functioning properly. Once they can be removed from the unit they will be stored to use as needed. During an interview with the Administrator on 6/27/19 at 6:39 PM she stated she had no idea which residents required , , , , , , or had access to portable , , tanks if needed during an emergency. She was unaware if any residents went without their , , , , during an extended power outage that had occurred on /19. In a follow-up interview with the Administrator conducted at 7:13pm, the Administrator acknowledged that there were concerns with the air conditioning working properly, dated prior to /2019. Class I	A 077		

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A 152	Continued From page 17	A 152		
A 152 SS=J	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of clothing or personal effects; 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not	A 152		

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A 152	Continued From page 18 be threadbare. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide a safe and decent living environment and to ensure that all existing electrical systems for cooling, as well as plumbing, and [redacted] storage were safely maintained and in good working order for 16 (#1, #2,#3,#4,#5,#6,#18, #19, #27,#29,#33,#35,#36,#37,#40, and #41) out of 47 residents sampled. The facility also failed to maintain apartments at a safe temperature and placed the resident's health and well-being at risk for 41 (#121,#218,#227,#206,#207,#230,#231,#233,#250,#251,#253,#254,#256 #258,#259 #262,#263, #264, #304, #307, #309,#313,#315,#316,#320,#322,#324,#326,#329,#331,#333,#335,#349, #350,#351,#352,#353,#354,#356,#358,#361, and #362) out of 119 apartments observed within the facility. Finding Included: On 5/14/2019 at 1:00 p.m. during a tour of the facility it was observed that the temperature varied throughout the facility. Resident interviews conducted on [redacted] /2019 revealed some of the resident's apartments were too hot. During the exit conference on 05/14/2019 at 7:15pm, the Administrator stated a new air conditioner tower had been proposed on 1/16/19 but it was refused by corporate. During an interview with Staff G on 6/26/19 at around 7:30pm, Staff G indicated that Resident	A 152		

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A	Continued From page 19 #1's room was very hot immediately prior to the resident leaving for the hospital. An interview was conducted with Resident #20 (Resident #1's roommate and family member) at 11:47 am on /19. Resident #20 stated the apartment he shared with Resident #1 was hot for a long time and the air conditioning (A/C) did not work. A closed record review on 6/27/2019 verified Resident #1 was admitted to facility on /18 with admitting diagnoses of , , , and , . Resident #1's health assessment was signed and dated by a healthcare professional on /2019. Resident#1 was noted as independent with all activities of daily living (ADL's). Resident #1 was discharged from the facility on /2019, reason noted as . A review of Resident #1's hospital records on 2019 revealed, Resident#1 arrived to a local hospital on /19 around 5:00pm with chief complaint "patient , air conditioning (A/C) has been out in (patient's) apartment." Oral temperature upon arrival was 102.9?. History of present illness revealed, Resident #1 was not eating, , and the onset of the illness was 5 days ago. The course/duration of condition was constant and worsening. Resident #1 was sent to the Critical Care Unit for treatment of , (skin warm, system, , system), , and , requiring and mechanical supervision. During an interview conducted on 06/25/2019 at approximately 11:00am with the Administrator, she stated the facility purchased and installed 23	A 152		

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A 152	Continued From page 20 chillers in resident rooms and hallways. Review of the Chiller receipt documentation found a date of 6/25/2019, which was the first day of the survey. Some of the chillers were removed, however, from resident rooms and placed in the dining area, according to the Maintenance Director. During an interview on 6/25/2019 with the Administrator and the Maintenance Director at approximately 3:00pm -----the timeline of events was as follows: " On /2019 at 3:00 p.m. the transformer went out and the entire facility lost electricity. " On /2019 at 4:00 p.m. the facility gained power. " On /2019 at 8:00 p.m. the entire facility lost electricity again. " On /2019 at 6:00 a.m. the facility gained power to certain parts of the facility and there was no working A/C throughout the facility. " From /2019 to /2019, the facility was without safe air temperatures for an approximately 10 hours. " From /2019 to /2019, the facility wasn't able to maintain safe temperature levels throughout the facility. On 19, the temperatures were measured in every apartment of the facility, including all the rooms where residents resided. Many of the temperatures exceeded 81 degrees. Some that were exceedingly high when measured in the evening between 2:00pm and 8:30pm were in (memory care) 84, 262-86, 258-85, 227-84, 304-82, 309-82, 313 -86, 315 - 85, 320 (resident on) - 83, 322 - 86, (room felt hot and stuffy), 324-82.7, 326-82.9, 329	A 152		

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A 152	Continued From page 21 - 87, 331 - 86, 333 - 84, 349-83.8?, 350 89?, 352 - 88, 354-87, 358 - 87, 358 (resident on [redacted]) - 89, and 361 - 82. On [redacted]/2019 the temperatures that exceeded 81 degrees were measured in the evening between 6:00pm and 8:30pm in apartments on the 2nd floor: 230- 82, 231-82?, 251-84, 253-84, 254-85.6, 256-88, 259-85, 263-87, 264-87, 3rd floor: 320-83, 335-82, 350-89?, 352-88?, 354-89?, 358-89?, 361-83?, 364-87?, 362-87?. On [redacted]/19 between 6:00pm and 8:30pm, some resident's apartment temperatures were measured between 82 degrees and 87 degrees. The evening of [redacted] /19, the Administrator provided AHCA with a list of 15 resident apartments (#206, #207, #233, #218, #250, #251, #256, #304, #322, #324, #358, #356, #307, #316, and #361,) they were planning to evacuate due to high temperatures. The Administrator stated that by midnight all 15 apartments would be evacuated and that the residents would be moved downstairs to the first floor where it was cooler, until the rooms could be cooled down. During an interview with the Administrator at 9:30am, the Administrator stated that only 2 residents had been moved out of their rooms during the night. On [redacted] /2019 the temperatures that exceeded 81 between 11:30am and 8:00pm in apartments on 2nd floor included 250-82 , 253-83, 254-84, 256-85, 263-82, and apartments on the 3rd floor included 329-82, 351-84, 353-84. Resident #4 was observed in his apartment at 3:15pm on [redacted]/19, with [redacted] running from an [redacted] concentrator, via [redacted]. At that time, approximately 10 [redacted] tanks were lined up against the wall, standing upright without	A 152		

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A 152	Continued From page 22 the stability of an . ,,. tank rack. This was noted to be a safety hazard. On at 10:15am, while touring the facility, along with the Administrator, the resident's room was again observed to have several . ,,. tanks stored in the same manner, with no ,, tank rack. On /2019, The National Weather service issued a heat advisory on ..../2019 from noon to 6:00 P.M. for Tampa Bay, warning that "the Heat Index could hover in the 108 to 110 degree range. The high temperatures increased the risk of dehydration, heat exhaustion, and heat stroke for people outdoors," the Weather Service said. On 6/26/19 during observations, the coolers were not being maintained, the water that collected in the tank needed to be emptied or the coolers would stop blowing cold air. A tour of the facility was conducted on 6/26/19 at 10:20am. A single ,, tank, sitting outside of apartment 358 in the hallway on the 3rd floor, was observed leaned up against the wall and stored unsafely, without an . ,,. tank rack or any other type of support (photographic evidence obtained). During an interview with the Administrator on 6/26/19 at 4:30pm, they stated they moved the tank into the hallway due to the heat in the resident's room. On /19 at 3:40pm, Resident #2 was observed sitting in the 2nd floor common area, their . . . were shaking, and Resident #2 stated, "I don't feel well because of the heat." Resident #2's . . . appeared to be flushed and the skin around her ,,. were bright pink. The thermostat on the chiller in the room read 88.5 degrees. The paramedics arrived at 4:05pm and their vital signs were taken by paramedics. Resident #2's	A 152		

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A 152	Continued From page 23 pressure reading from paramedics was . . . . (high). A paramedic stated Resident #2's condition was affected by heat and it can't help with a bad A/C. The paramedics said of resident's . . . . condition "your . . . is not very happy right now". A review of the hospital record on . . . . /2019 for Resident #2 revealed Resident#2 was to return back to the facility however the facility stated that the air condition unit was not working, and it is was not safe for the Resident #2 to return to the facility. During a third-floor tour on 6/27/19 at approximately 9:32 AM an activity office was noted to have standing water on the floor and there were missing and stained tiles from the ceiling. The Activity Office is located on a floor with resident rooms. Observed were two trash cans collecting water from the ceiling. The Activity Director stated that the water had been leaking, resulting in standing water, for 2 months and, while facility staff were aware, no action had been taken. This impeded residents from coming into the office to ask the Activity Director questions. Between the door to her office and her desk at the far wall she had been walking through standing water for 2 months. [Photographic Evidence obtained]. On 6/27/2019 at 9:41 a.m., surveyors were informed by an A/C repair person that the facility's system could not take any more load. They were trying to install brand new window units in resident bedrooms and it caused an overload. A chiller in the second-floor common area shut down as a result. According to the thermostat on the chiller it was 82 degrees after only 10 minutes as stated by 2 residents and a visitor sitting in this area. (Photographic evidence obtained).	A 152		

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A 152	Continued From page 24 On 6/27/19 at 9:47 a.m., surveyors observed the facility "thrift store" on the second floor which is run by a resident volunteer. The room was hot upon entrance and the vent was blowing hot air. The resident volunteer stated she had reported her concern to the Administrator over the past 2 months and stated she could not take it anymore and would not be overseeing the thrift store anymore due to the ongoing heat. During an interview with Resident #3 on /2019 at 1:32 PM, Resident #3 stated on /2019 and /2019 his room reached temperatures of 85 degrees and felt terrible. Resident #3 stated he required daily yet he was not able to breath on /2019 when the facility's air conditioner and electricity went out. Resident #3 stated, "When you say to staff hey! I can't breathe, I have no , and someone say "ok" and leaves and never come back to help, that's the most frighten feeling ever, I felt like jumping out of the window because of the heat." An interview conducted on /2019 at 12:45pm, Resident #5 stated the facility lost power on /2019 at 4:00 am and at that time she felt extremely overheated, drained and was without for over almost an hour. Resident #5 stated she couldn't breathe and required continuous . Resident #6 was interviewed on /2019 at 12:58 PM, she stated, "Monday night (/19) was the worst night of my life, it was so hot inside this room and I felt terrible, I all of a sudden had , I slept all day and have no energy what so ever!" Resident #6 stated she required because she had a hard time breathing and being exposed to hot temperatures made it	A 152		

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A 152	Continued From page 25 difficult for her to breathe. She recalled her room's temperature was 85 degrees and above on ... /2019. Resident #17 was interviewed on ... /2019 at 1:25 PM. He stated on /2019 he had no idea what was going on, all he knew was all of a sudden, his room's temperature had climbed from 76 degrees to 89 degrees overnight. He stated he was in distress and couldn't breathe. He stated he had (. . . .)- . . . . . , ... , which made it harder for him to breath. He stated he wasn't moved from his room to a cooler area and he suffered from blistering temperatures for two days. Resident #18 was interviewed on ... /2019 at 1:39pm. He stated his room was always boiling and he was not sure why. He told staff members about the boiling temperature, yet no one did anything to fix the problem. Resident #18 stated on /2019 and /2019 the temperatures in his room were in the high 80's. During an observation on /2019 at 1:39pm, the thermostat in the room read 84 degrees. On 6/25/2019 at 4:00 PM during an interview with the administrator, she acknowledged the facility had various locations that were over 86 degrees. During an interview with the Administrator conducted on 6/27/19 at 6:39pm, the Administrator confirmed the residents were exposed to extreme heated temperatures above 86 degrees since ... /2019. In a follow-up interview conducted at 7:13pm, the Administrator acknowledged that there were concerns with the air conditioning working properly, dated prior to ... /2019.	A 152		

Agency for Health Care Administration

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	AL11963958	A. BUILDING: _____ B. WING _____	06/28/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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