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 |
|---|---|---|---|
| | AL11943041 | A. BUILDING: _____ B. WING _____ | 09/24/2026 |

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| BAYTREE LAKESIDE | 6411 46TH AVENUE NORTH SAINT PETERSBURG, FL 33709 |

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| A 000 | Initial Comments<br><br>A complaint investigation (complaint numbers: 20260015579 and 2026002823) and a generator monitoring visit were conducted at Baytree Lakeside on . Deficiencies were identified at the time of survey. | A 000 | | |
| A 032 SS=D | 59A-36.007(7) FAC Resident Care - Elopement Standards<br><br>59A-36.007<br>(7) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.<br>1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.<br>2. The facility must have a photo identification of at risk residents on file that is accessible to all | A 032 | | |

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| A 032 | Continued From page 1<br><br>facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.<br>(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:<br>1. An immediate search of the facility and premises,<br>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,<br>3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,<br>4. The continued care of all residents within the facility in the event of an elopement.<br>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure that all direct care staff and administration had participated in two elopement drills per year for eight (Staff D, Staff E, Staff F, Staff G, Staff H, Staff I, Staff J, and Staff K) of eight sampled employees.<br><br>Findings included: | A 032 | | |

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| A 032 | Continued From page 2<br><br>A review of the facility's elopement drills, conducted on , revealed the facility's elopement drills were signed by each staff person that participated in them. The elopement drills reviewed were dated at 3:00 PM, at 2:18 PM, at 2:45 PM, at 7:20 AM, at 4:00 PM, no date at 7:00 AM, at 4:18 PM, at 4:00 PM, at 3:00 PM, and at 4:46 AM. There were five employees that did not participate in any of the elopement drills which included Staff F, Staff G, Staff H, Staff I, and Staff J. There were three employees that completed one elopement drill participation which included Staff D, Staff E, and Staff K.<br><br>During an interview on at 1:58 PM, the Administrator agreed Staff F, Staff G, Staff H, Staff I, and Staff J had not been participated in any elopment drills. The Administrator agreed Staff D, Staff E, and Staff K had only particpated in one elopement drill for the year.<br><br>Class III | A 032 | | |
| A 052 SS=D | 429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin<br><br>429.256<br>(3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered | A 052 | | |

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| A 052 | Continued From page 3<br>medications in previously dispensed, properly labeled containers.<br>(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.<br>(c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her .<br>(d) Applying , medications.<br>(e) Returning the medication container to proper storage.<br>(f) Keeping a record of when a resident receives assistance with self-administration under this section.<br>(g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the .<br>(4) Assistance with self-administration of medication does not include:<br>(a) Mixing, , , converting, or , medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.<br>(b) The preparation of syringes for injection or the administration of medications by any injectable | A 052 | | |

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| A 052 | Continued From page 4<br><br>route.<br>(c) Administration of medications by way of a tube inserted in a , of the body.<br>(d) Administration of , preparations.<br>(e) The use of irrigations or debriding agents used in the treatment of a skin condition.<br>(f) Assisting with , , , or , preparations.<br>(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.<br>(h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.<br>(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.<br><br>59A-36.008<br>(3) ASSISTANCE WITH SELF-ADMINISTRATION.<br>(a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. | A 052 | | |

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| A 052 | Continued From page 5<br><br>(b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.<br>(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.<br>(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.<br>(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:<br>1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,<br>2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,<br>3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or<br>4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit | A 052 | | |

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| A 052 | Continued From page 6<br><br>dose packaging.<br>(f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S.<br>(g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.<br>(h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure unlicensed Medication Technicians popped the pills out of the pill packs in front of the residents, informed residents of the names and doses of the medications, and observed the residents take and swallow the medications for two (Resident #10 and Resident #11) of two sampled residents<br><br>Findings included:<br><br>During an observation of the medication pass conducted on at 12:15 PM with Staff J (an unlicensed Medication Technician) for Residents #10 and #11, the following was observed: Staff J popped medications at the medication cart with no residents present and without opening any medication observation records (MORs) for review. Staff J popped one pill into a plastic medication cup, then placed that pill pack into the medication cart. She then retrieved a pill for a different resident and popped that pill into another medication cup. Staff J took both medication cups to Resident #11 ' s room, knocked on the closed door, and entered. An | A 052 | | |

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| A 052 | Continued From page 7<br><br>individual inside the room informed Staff J that Resident #11 was not present and had gone to the store. Staff J then left the room and proceeded to Resident #10 ' s room. She knocked on the closed door, opened it, and entered. Staff J placed the medications and a cup of water on the television stand and asked, "Is this okay right here?" She then exited Resident #10 ' s room and closed the door.<br><br>During an interview on at 12:17 PM, Staff J stated Resident #10 liked to take his medication in privacy.<br><br>During an interview on at 1:50 PM, the Administrator stated staff were to witness residents take their medications and Staff J would need to go through training.<br><br>Class III | A 052 | | |
| A 054 SS=D | 59A-36.008(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use.<br>(b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is | A 054 | | |

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| A 054 | Continued From page 8<br><br>offered or administered and include:<br>1. The name of the resident and any known<br>the resident may have;<br>2. The name of the resident's health care provider and the health care provider's telephone number;<br>3. The name, strength, and directions for use of each medication; and,<br>4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.<br>(c) For medications that serve as chemical<br>, the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to immediately update medication observation records (MORs) when medications were offered or given to two (#10 and #11) of two sampled residents.<br><br>Findings included:<br><br>A record review of Residents #10 and #11's MORs, conducted on , revealed there were multiple times in when medications were not documented as given to Resident #10 and Resident #11. Furthermore, there was no explanation as to the reason the medications were not given.<br><br>During an interview on at 1:55 PM, the Administrator reviewed Resident #10 and Resident #11's MORs and agreed there were medications that were not immediately updated on the residents' MORs. | A 054 | | |

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| A 054 | Continued From page 9<br>Photographic evidence obtained.<br><br>Class III | A 054 | | |