STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on record reviews and interviews, the facility failed to ensure there was a physician order for the code status of Do Not Resuscitate (DNR), and that the DNR code status was accurate on the electronic medical record, or that a care plan was in place for the Advance Directives for one resident (Resident #63) out of the sampled thirty-two residents. Findings included: A review of the Admission Record revealed that Resident #63 was initially admitted into the facility on [DATE]. Section C-Cognitive Patterns of the Minimum Data Set (MDS) dated [DATE] indicated that Resident #63 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating cognitively intact. A review of the resident's current physician orders for February 2021 revealed an order for full code dated 01/21/21. A review of the banner on the electronic medical record indicated that Resident #63's code status was full code. A review of the documents listed under the miscellaneous tab on the electronic record revealed a State of Florida Do Not Resuscitate (DNR) Order form dated 01/20/21. The resident did not have a care plan in place for Advanced Directives. On 02/25/21 at 11:30 a.m., Staff H, Licensed Practical Nurse (LPN), reported if a resident was to code, she would grab the paper chart plus the crash cart, or look at the banner in the electronic chart. Staff H was asked to confirm Resident #63's code status. Staff H, referred to the paper chart and the electronic banner and then she stated, Does not look like she is a DNR, and there is nothing in the advanced directives section, so she is full code. During an interview on 02/26/21 at 10:33 a.m. with Resident #63, she was asked about her code status. She stated, Do not resuscitate me. I have had a rough life. Let me go. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/21 at 10:55 a.m., the Regional Clinical Director/ Interim Director of Nursing (DON) was asked what was the correct code status for Resident #63 after showing her the current physician order and electronic banner stating full code and the DNR form dated 01/20/21. She stated the resident should be DNR. On 02/26/21 at 11:41 a.m., the Interim DON stated staff should look at the orders for code status. There was also a code status book on each unit and she confirmed Resident #63 was a DNR. A review of the facility policy titled, Advanced Directives, reviewed date of 5/24/16, documented the policy as, The resident has the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. The procedure section revealed: 5. The attending physician must document in the medical record the discussion with the resident or surrogate regarding choices and decision of advance directives. a. Upon executing any valid Advance Directive, the designated paperwork will be placed in the resident's medical record, under the Advance Directive tab .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on observations, record reviews, and interviews, the facility failed to implement the care plan related to a wander/elopement alarm for one resident (Resident #71) out of the total sample of thirty-two residents. Findings included: On 02/25/21 at 11:19 a.m., Resident #71 was observed in bed sleeping and a wander/elopement alarm was observed on his right ankle. A review of the Admission Record revealed that Resident #71's most recent admitted was 01/25/21. The resident's diagnoses included, but were not limited to, dementia with Lewy Bodies, major depressive disorder, and mood disorder. A review of Section C- Cognitive Patterns of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #71 had a Brief Interview for Mental Status (BIMS) score of 07 out of 15, indicating severe impairment. A review of the active physician orders as of 02/26/21 for Resident #71 revealed an order to apply a wander/elopement alarm to the right ankle due to poor safety awareness dated 02/12/21. There was no physician order for checking the placement and functioning of the wander/elopement alarm. Resident #71 had a care plan in place for risk of elopement initiated on 02/12/2021. The interventions included, but were not limited to, an alerting bracelet placed on the right ankle, check alerting bracelet function every day, and check alerting bracelet placement every shift. A review of the task screen for certified nursing assistants revealed that there was a task related to checking the functioning and placement of the wander/elopement alarm, but there was no documentation showing the placement and functioning of the wander/elopement alarm was conducted. A review of the Treatment Administration Record (TAR) for February 2021 revealed that there was no documentation related to checking the functioning and placement of the wander/elopement alarm. On 02/25/21 at 11:20 a.m., Staff H, Licensed Practical Nurse (LPN), reported that the nurses and Certified Nursing Assistants (CNAs) were responsible for checking the placement and functioning of the wander/elopement alarms. On 02/26/21 at 8:50 a.m., the Regional Clinical Director/ Interim Director of Nursing (DON) stated nurses are supposed to check the functioning of the wander/elopement alarms. The CNAs can check them, but usually it was the nurses. On 02/26/21 at 10:20 a.m., Staff H, LPN, confirmed that there was no documentation related to checking of the functioning and placement of the wander/elopement alarm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/21 at 11:41 a.m., the Interim DON confirmed that there was no documentation related to checking the functioning of the wander/elopement alarm. She stated that the previous DON did not enter the orders correctly. The policy provided by the facility title, Wander/Elopement Alarm System Testing, with a reviewed date of 05/24/16 revealed the following: Signaling Device Placement Verification 1. Perform regular and frequent checks to verify the operation of signaling device(s). Signaling Device Testing 1. Test signaling devices at least daily. Documentation 1. Document verification of placement and test for all signaling devices daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39438 Based on record reviews and interviews, the facility failed to ensure treatment and care in accordance with professional standards of practice for one resident (Resident #71), by failing to notify the physician of elevated glucose levels as ordered by the physician, out of the total sample of thirty-two residents. Findings included: A review of the Admission Record revealed that Resident #71's most recent admitted was 01/25/21. The resident's diagnoses included, but were not limited, to Type II diabetes, dementia with Lewy Bodies, major depressive disorder, and mood disorder. A review of Section C- Cognitive Patterns of the Minimum Data Set (MDS) dated [DATE] revealed that Resident #71 had a Brief Interview for Mental Status (BIMS) score of 07 out of 15, indicating severe impairment. A review of the active physician orders as of 01/25/21 revealed the following order: blood glucose checks before meals and at bedtime for diabetes mellitus fingerstick. Call medical doctor if blood sugar <60 or >250. A review of the Medication Administration Record (MAR) for January 2021 revealed that Resident #71's blood sugar was higher than 250 on the 26th and 29th-31st of January 2021. A review of the MAR for February 2021 revealed that Resident #71's blood sugar was higher than 250 on the 1st-6th, 8th, 10th-15th, 21st, and 23rd of February 2021. A review of the progress notes from 01/24/21 to 02/26/21 revealed that there was no documentation related to contact with the medical doctor in regard to Resident #71's blood sugars being higher than 250. On 02/25/21 at 11:20 a.m., Staff H, Licensed Practical Nurse (LPN), stated that the order was inaccurate for the blood glucose checks, and that she had not been contacting the doctor if the blood sugars were higher than 250. She stated that she would have to get the order clarified. On 02/26/21 at 8:50 a.m., the Regional Clinical Director/ Interim Director of Nursing (DON) stated that she would expect the nurses to contact the doctor. A review of the policy titled, Physician Orders, revised on 10/24/17, revealed the purpose as, Physician orders are obtained to provide a clear direction in the care of the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on interviews and record reviews, the facility failed to provide ordered medications in a timely manner to one resident (#240) of 32 sampled residents. Findings included: A review of Resident #240's medical record revealed that Resident #240 was admitted to the facility on [DATE] with diagnoses of osteoarthritis, Alzheimer's Disease, and nondisplaced fracture of fourth cervical vertebra. A review of Resident #240's care plan revealed a problem, dated 02/10/2021, that Resident #240 was at risk for pain. Interventions included administer analgesics as ordered. A review of Resident #240's physician's orders revealed an order, dated 02/10/2021, for Tramadol 50 milligrams (mg) by mouth in the morning for severe pain control, which was discontinued on 02/13/2021. Resident #240's physician's orders also revealed an order, dated 02/14/2021 for Tramadol 25 mg by mouth in the morning for pain. A review of Resident #240's Medication Administration Record (MAR) for February 2021 revealed that Tramadol 50 mg was administered one time on 02/11/2021 and Tramadol 25 mg was administered on 02/07/2021 and 02/08/2021. The MAR documentation revealed a chart code of 9 on 02/10/2021, 02/12/2021, 02/14/2021 through 02/16/2021, and 02/19/2021 through 02/25/2021. The chart code of 9 was described as Other/See Nurse Notes, on the Chart Codes table. A chart code of 6 was documented on the MAR on 02/13/2021. The chart code of 6 was described as hospitalized , on the Chart Codes table. A review of Resident #240's Progress Notes revealed the following documentation: - eMAR (electronic Medication Administration Record) Medication Administration Note, dated 02/11/2021 at 05:50 AM: Tramadol 50 mg: Prescription needed. MD (Doctor of Medicine) service called at this time. - eMAR Medication Administration Note, dated 02/12/2021 at 06:20 AM: Tramadol 50 mg: Med not available; waiting for pharmacy delivery. - eMAR Medication Administration Note, dated 02/14/2021 at 05:50 AM: Tramadol 25 mg: Medication not available. - eMAR Medication Administration Note, dated 02/15/2021 at 05:38 AM: Tramadol 25 mg: Medication unavailable, script needed, will contact physician. - eMAR Medication Administration Note, dated 02/16/2021 at 06:22 AM: Tramadol 25 mg: Medication unavailable, script needed, will contact physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- eMAR Medication Administration Note, dated 02/17/2021 at 05:23 AM: Tramadol 25 mg: Prescription needed. - eMAR Medication Administration Note, dated 02/18/2021 at 05:53 AM: Tramadol 25 mg: Prescription in progress. - eMAR Medication Administration Note, dated 02/19/2021 at 05:29 AM: Tramadol 25 mg: Med not given due to waiting for pharmacy delivery. - eMAR Medication Administration Note, dated 02/20/2021 at 07:16 AM: Tramadol 25 mg: Medication unavailable for administration. Attending nurse to contact pharmacy. - eMAR Medication Administration Note, dated 02/21/2021 at 05:54 AM: Tramadol 25 mg: Medication unavailable. - eMAR Medication Administration Note, dated 02/22/2021 at 05:19 AM: Tramadol 25 mg: Medication not available. - eMAR Medication Administration Note, dated 02/23/2021 at 06:27 AM: Tramadol 25 mg: Medication not available, physician contacted. - eMAR Medication Administration Note, dated 02/24/2021 at 06:02 AM: Tramadol 25 mg: Awaiting for delivery. - eMAR Medication Administration Note, dated 02/25/2021 at 05:54 AM: Tramadol 25 mg: Medication not available. An interview was conducted on 02/26/2021 at 8:59 a.m. with the facility's Director of Nursing (DON). The DON stated that when a new order is entered into the electronic charting system, then the medication can be pulled from the medication storage system as long as the resident had a prescription. Medication cards would normally arrive by the next morning, but could be pulled from the medication storage system if needed before then. The DON stated that she would expect nursing staff to follow up with the pharmacy if the medication did not arrive timely and document the follow up in the charting system. The DON also stated that Tramadol was available in the medication storage system and that there's no reason why Resident #240 should not have gotten the medication as ordered. An interview was conducted on 02/26/2021 at 9:19 a.m. with Staff I, Licensed Practical Nurse (LPN). Staff I, LPN stated that Resident #240 still needed a prescription for her Tramadol and that the medication was not delivered from pharmacy. Staff I, LPN stated that the medication was placed on hold because they did not have the medication in yet. Staff I, LPN also stated that it did not normally take that long for a medication to arrive and that the matter should have been followed up on by nursing staff. Tramadol would be available in the medication storage system. An interview was conducted on 02/26/2021 at 10:02 a.m. with Staff J, Registered Nurse (RN). Staff J, RN stated that Resident #240's Tramadol was placed on hold yesterday 02/25/2021 by the pharmacy due to a possible allergy. Normal practice would be for nursing staff to call the physician right away, but Staff J, RN was not able to state why Resident #240's medication orders were not followed up on. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 03/04/21 at 2:16 p.m. with the facility's Consultant Pharmacist, who stated that when a new medication was ordered the nursing staff would obtain a prescription from the provider, fax the prescription to the pharmacy, and enter the order into the electronic system. If the medication was needed right away, nursing staff could call the pharmacy and obtain an authorization code to enter into the medication storage system to obtain a dose. If the medication was needed right away and it was not in the medication storage system, the nursing staff could make a STAT (immediate) request and the pharmacy would deliver the medication within 4 hours. A review of the facility's medication storage system list revealed that Tramadol 50 mg was available in the storage system. A review of the facility policy titled, Ordering & Receiving Medications, revised on 05/22/2018, revealed that all new orders should be sent electronically when possible to the pharmacy for processing. If unable to send an order electronically the order may be faxed to the pharmacy. When sending a STAT order to the pharmacy, the nurse must immediately call the pharmacy and inform them of the STAT nature of the order. The policy also revealed that Schedule II narcotic medications will be dispensed by the pharmacy after receiving a signed prescription written by the prescribing physician. In some situations, the pharmacy may dispense a short supply of the medication when given a verbal order from the prescribing physician to the pharmacist. This allows the physician time to get the written signed prescription to the pharmacy if the facility has a hard copy of the schedule II medication, a copy should be faxed to the pharmacy with the medication order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38238 Based on observation, interview and record review, the facility failed to 1) ensure behavioral monitoring for psychotropic medications was consistently documented for two residents (#25 and #240) of five residents reviewed, 2) obtain and consistently complete consents for use of psychotropic medications for four residents (#25, #240, #71 and #39) of five residents reviewed, and 3) perform blood glucose monitoring for one resident (#25) receiving insulin of five residents reviewed. Findings included: A record review for Resident #25 revealed an admitted [DATE], with diagnosis that included Major Depressive Disorder (MDD) and Diabetes as per the admission face sheet. A review of the Quarterly Minimum Data Set (MDS) dated [DATE] showed under Section C, Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact, Section N, Insulin, antidepressant, anticoagulant and diuretic received on 7 out of 7 days. A review of the Medication Administration Record (MAR) included the following medications: -Remeron 15 mg (milligrams) orally at bedtime for MDD with a start date of 01/21/2021 -Insulin 70/30 12 units in the morning subcutaneously for diabetes with a start date of 12/30/2020. Further review of the MAR revealed an order for fasting blood sugar each morning with a start date of 12/23/2020 and a discontinue date of 02/09/2021. No further orders for blood glucose monitoring were identified, nor was any other blood glucose measurements contained within the resident's record since the discontinuation of this order. Review of the Physician Orders for Resident #25 revealed: Psychoactive Medication: Document number of targeted behaviors, behavior code, intervention code, outcome of intervention code, and side effect code every shift, with a start date of 11/11/2020. A review of the Behavior Monitoring Record for 1) January 2021 revealed 14 shifts without documentation present; the missing shifts occurred on multiple different days of the week; and 2) February 2021 (to date) revealed 16 shifts without documentation present; the missing shifts occurred on multiple different days of the week. A review of the Psychoactive Medication Consent for Resident #25 revealed a drug dosage and frequency of 'Remeron 15 mg QHS [at bedtime]', with a targeted behavior of 'appetite'; the Potential Side Effects section was not completed. The form was signed by the resident on 12/7/20. A review of the Care Plan for Resident #25 initiated on 02/02/2021 showed: Focus: Resident uses psychotropic medications r/t [related to] depression (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goal: Resident will remain free of drug related complications including movement disorder, discomfort. Hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through the review date. Target date: 05/17/2021 Interventions included: Monitor occurrence of target behaviors and monitor specific target behaviors; possible risk and casual/contributing factors for behaviors, desired outcomes, ongoing efficacy of individualized/non pharmalogical approaches and potential for adverse consequences. An observation of Resident #25 was conducted on 02/25/2021 at 3:47 p.m. The resident was observed seated in a chair in his room watching TV. He was dressed and groomed with no odors noted. The resident refused an interview. A facility-provided policy titled Psychotropic Medication Assessment and Monitoring dated 10/30/2018 was reviewed. It revealed: b) Psychoactive Medication consent signed by the resident/resident representative d) Monitoring of residents receiving antipsychotic medication will be completed by a licensed nurse as per acceptable standards of practice using the behavior monitoring record. During an interview with the Interim Director of Nursing (DON) on 02/26/21 at 9:07 a.m., she stated it was her expectation that blood sugar monitoring would occur for a resident who is receiving regular doses of insulin. The DON further stated it is her expectation that behavioral monitoring is completed every shift for residents receiving psychoactive medications. Additionally, she said the facility uses a 'Baylor plan', meaning the weekends are covered by 12 hour shifts and the weekdays are covered by 8 hour shifts. She clarified it was a possibility that during the weekends, behavioral monitoring would only occur twice in 24 hours as there would only be two shifts. She confirmed that this represented a different care process on the weekend versus during the week. The DON also confirmed Psychoactive Medication Consent forms should have all sections completed, including the 'potential side effects' section. An interview was conducted with the Consultant Pharmacist on 02/26/21 at 3:29 p.m. She stated it was her expectation that residents receiving regular insulin would have their blood glucose checked regularly. Additionally, she stated if there was a Physician's Order for behavioral monitoring related to antidepressant use, it should be documented in the record. 40775 2. A review of Resident #240's medical record revealed that Resident #240 was admitted to the facility on [DATE] with diagnoses of dementia, anxiety disorder, Alzheimer's Disease, and Major Depressive Disorder. A review of Resident #240's Care Plan revealed a problem, revised on 02/18/2021, that Resident #240 used psychotropic medication related to anxiety and Major Depressive Disorder with psychotic features. Interventions included monitor occurrence of target behavior symptoms, obtain consent from resident or responsible party, and monitor for side effects and adverse reactions of psychotropic medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #240's MDS assessment revealed, under Section C - Cognitive Patterns, a BIMS score of 99, which indicated that Resident #240 was not able to complete the interview. The MDS assessment also revealed, under Section N - Medications, that Resident #240 received antipsychotic medications and antidepressant medications 6 days out of the 7 day assessment period and antianxiety medications 7 days out of the 7 day assessment period. A review of Resident #240's Physician's Orders revealed the following orders: - Psychoactive Medication: (Risperdal) Document number of targeted behaviors, behavior code, intervention code, outcome of intervention code, and side effect code every shift, with a start date of 02/10/2021. - Psychoactive Medication: (Trazodone) Document number of targeted behaviors, behavior code, intervention code, outcome of intervention code, and side effect code every shift, with a start date of 02/10/2021. - Psychoactive Medication: (Xanax) Document number of targeted behaviors, behavior code, intervention code, outcome of intervention code, and side effect code every shift, with a start date of 02/10/2021. - Psychoactive Medication: (Zoloft) Document number of targeted behaviors, behavior code, intervention code, outcome of intervention code, and side effect code every shift, with a start date of 02/10/2021. - Xanax 0.25 mg by mouth two times a day for anxiety, with a start date of 02/10/2021. - Risperdal 1.5 mg by mouth at bedtime for behavioral and psychological symptoms of dementia (BPSD), with a start date of 02/10/2021. - Zoloft 100 mg by mouth one time daily for depression, with a start date of 02/10/2021. - Trazodone 12.5 mg by mouth every 8 hours for depression, with a start date of 02/10/2021. A review of Resident #240's Behavior Monitoring record for February 2021 revealed that psychoactive medication monitoring for Risperdal was not completed on five different shifts, which occurred on multiple days. A review of Resident #240's Psychoactive Medication Consent form revealed, under the section titled Medication Interventions Recommended the medications Xanax, Zoloft, Trazodone, and Risperdal. The documentation did not include dosage or frequency of the medication as part of the consent. The section titled Potential Side Effects revealed side effects for Xanax and Risperdal as lethargy and side effects for Zoloft and Trazodone as N/V (nausea and vomiting). No other medication side effects were listed in the section. The Consent form also revealed, under the section titled Statement of Consent, that no selection was made related the consent for use of psychotropic medications. The bottom of the consent form revealed that the consent form was completed on 02/24/2021. 39438 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A review of the Admission Record revealed that Resident #71's most recent admitted was 01/25/21. The resident's diagnoses included but were not limited to dementia with Lewy Bodies, major depressive disorder, and mood disorder. A review of the Psychoactive Medication Consent dated 01/25/21 revealed that Resident #71 was ordered Lexapro 10 mg for depression with potential side effects of lethargy and Nuplazid 34 mg for hallucinations with a potential side effect of lethargy. The Statement of Consent portion of the consent was left blank. The form indicated verbal consent via telephone with family member but did not indicate whether the family consented or did not consent to the use of the medications. The section for the person completing the form was left blank. 43145 4. A record review of the medical record for Resident #39 revealed that she was initially admitted to the facility on [DATE] and readmitted on [DATE]. Diagnoses included: Unspecified dementia without behavioral disturbances, major depressive disorder, schizoaffective disorder, bipolar type, pseudobulbar affect, and anxiety disorder. A review of Resident #39's MAR for January 2021 revealed physician orders for: Risperdal 0.25 milligrams(mg) by mouth (PO) every morning, Risperdal 0.5 mg PO every evening, for Schizoaffective disorder, Zoloft 50 mg in the morning for major depressive disorder, Namenda 10 mg 1 tab PO two time daily (BID)for dementia, Nuedexta capsule (cap) [capsule] 20-10 mg 1 cap po BID for pseudobulbar affect, and Xanax 0.5 mg PO three times daily (TID) for anxiety. A review of Resident #39's care plan revealed that Resident #39 uses psychotropic medications for anxiety, depression, and schizoaffective disorder, bipolar type. Interventions included: Consult with pharmacy, provider to consider dose reduction; Describes how the medication impact the resident and others; Discussed with provider ongoing need for use of medication; Monitor for specific target behaviors: possible risk and causal/contributing factors for behavior, desired outcomes, ongoing efficacy of individualized/non pharmacological approaches . A review of Resident #39's medical chart and electronic medical record (EMR) did not reveal a Psychoactive Medication Consent form. During an interview with the Director of Nursing (DON) on 2/26/2021 at 11:00 a.m., the DON confirmed that the Psychoactive Medication Consent should have been uploaded in Resident #39's medical chart or EMR. Upon request for a Psychotropic Medication Consent for Resident #39 the DON provided a Psychotropic Medication Consent dated 2/26/2020. The DON stated that the Psychotropic Medication Consent was not completed prior to the request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38238 Based on observation, interview and policy review, the facility failed to ensure expired medications were removed from one medication cart (3rd floor back hall) out of three medication carts observed, and one medication storage room (3rd floor unit) out of one medication storage room observed. Findings included: On 02/25/2021 at 2:17 p.m. an observation of the 3rd floor back hall medication cart was performed and Staff C, Licensed Practical Nurse (LPN) was present. One card of Baclofen 5 milligram (mg) tablets with an expiration date of 11/25/2020 for Resident #33 was discovered. A subsequent interview with Staff C, LPN confirmed the medication was expired, and she further stated the medication was discontinued. On 02/25/2021 at 2:25 p.m. an observation of the 3rd floor medication storage room was performed and Staff C, LPN was present. Two bottles of Aspirin 81 mg tablets were discovered with an expiration date listed as 01/21. Additionally, during an observation of the medication room refrigerator, one box of Bisacodyl 10 mg Suppositories was discovered with an expiration date listed as 12/2020. A subsequent interview with Staff C, LPN confirmed both medications were expired. During an interview with the Interim Director of Nursing (DON) on 02/26/2021 at 9:34 a.m., she confirmed it was her expectation that expired medications were removed from the medication carts and storage rooms and returned to the pharmacy. She further stated the Unit Manager is responsible for doing weekly checks of medication storage areas to ensure expired medications are removed, and the Consultant Pharmacist also checks the carts monthly during her visits to the facility. A facility-provided policy titled, Storage and Expiration of Medications, Biologicals, Syringes and Needles, dated 12/1/07, and revised on 5/1/10 and 1/1/13 was reviewed. Under Section 4 it showed: Facility should ensure that medications and biologicals: 4.1 Have an expiration date on the label; 4.2 Have not been retained longer than recommended by the manufacturer or supplier; or; 4.3 Have not been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. During an interview with Staff A, Registered Nurse (RN), Unit Manager on 02/26/2021 at 11:00 a.m. she stated she has not been at the facility long, and has not got into a routine yet for checking the medication carts weekly for expired drugs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with the Consultant Pharmacist on 02/26/2021 at 2:26 p.m. revealed it was her expectation that expired medications were removed from the medication carts and storage rooms and returned to the Pharmacy. She further stated she checks medications for expiration dates during her visits to the facility and the nursing staff is responsible for checking between her visits to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775 Based on interviews and record review, the facility failed to implement the antibiotic stewardship program by not ensuring antibiotics were given appropriately to one resident (#244) of a total of 32 sampled residents. Findings included: A review of Resident #244's medical record revealed that Resident #244 was admitted to the facility on [DATE] with diagnoses of congestive heart failure, chronic atrial fibrillation, malignant neoplasm of prostate and benign prostatic hyperplasia with lower urinary tract symptoms. A review of Resident #244's February 2021 physician orders revealed the following orders: - 02/20/2021 Urinalysis (UA) with reflex to culture, discontinue this order when completed and sent; discontinued on 02/20/2021. - 02/25/2021 Urinalysis (UA) with reflux to culture, discontinue this order when completed and sent. - 02/20/2021 Ciprofloxacin 250 milligrams (mg) by mouth every 12 hours for infection for 7 days. A review of Resident #244's progress notes revealed a Health Status Note, dated 02/26/2021 at 08:51 a.m., which documented that a urine specimen was collected via straight catheterization using sterile technique and, UA being sent to lab as STAT (immediately), C&S (Culture and Sensitivity) specimen cup in dirty utility fridge for tomorrow AM lab pickup. Resident #224's progress notes did not reveal that the UA order for 02/20/2021 was completed. An interview was conducted on 02/26/2021 at 12:53 p.m. with the facility's Infection Preventionist (IP). The IP stated that Resident #244's lab work for the use of Ciprofloxacin may not have been loaded into the electronic charting system and that it may have been started before the resident came to the facility. The IP also stated that she reviewed the use of antibiotics on a weekly basis and that Resident #244 was recently added to her list since he was a new admission to the facility. A follow up interview was conducted on 02/26/21 at 01:53 p.m. with the facility's IP. The IP stated that Resident #244's urine culture was ordered on 02/21/2021 and that the Ciprofloxacin 250 mg was started before the collection was completed. The IP stated that the nursing staff did not complete the UA order from 02/20/2021 in a timely manner and that the antibiotic therapy continued until the urine was collected on 02/25/2021. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105650	A. Building B. Wing	02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshore Pointe Nursing and Rehab Center	3117 W Gandy Blvd Tampa, FL 33611

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 02/26/2021 at 01:59 p.m. with Staff J, Registered Nurse (RN). Staff J, RN stated that Resident #244 was started on Ciprofloxacin 250 mg prophylactically due to increased confusion. The UA was ordered for 02/20/2021 and was completed on 02/26/2021. Staff J, RN stated that Resident #244 was on antibiotic therapy before the UA was completed and stated that the UA should have been completed within one day. Staff J, RN was not able to state whether nursing staff should obtain the UA before initiating antibiotic therapy, and was not able to state why the UA was not completed sooner. An interview was conducted on 02/26/2021 at 02:10 p.m. with the facility's Director of Nursing (DON). The DON stated that lab work would be reviewed to determine if the antibiotic therapy was appropriate for the resident. The DON stated that a UA should be collected prior to beginning antibiotic therapy and should be collected within 24 hours from receiving the order. The DON stated that antibiotic use was reviewed and discussed during morning meetings, but they did not identify an issue with Resident #244's antibiotic therapy. A review of the facility policy titled, Antibiotic Stewardship, dated 10/24/2017, revealed under the section titled, Resident Assessment and Communication of Change in Condition, that when facility staff suspects a resident has an infection, the nurse should perform and document an assessment of the resident using established and accepted assessment protocols to determine if the resident's status meets minimum criteria for initiating antibiotics. The policy also revealed that when a culture and sensitivity (C&S) is ordered, it should be performed before the initiation of an antibiotic/anti-infective.