STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105071	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYSIDE CARE CENTER	811 JACKSON ST N SAINT PETERSBURG, FL 33705

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 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure proper procedures were followed before administering medication for one (Resident #48) observed, of 3 total residents in the facility with gastric tubes (GT). Findings included: A facility provided policy titled, 6.5 Medication Administration: Administration by Enteral Route dated 7/01/2013, with revision date September 1/01/13, Page 01 of 02 reads: PURPOSE: To provide guidelines for administration of medication via enteral routes. MEDICATION ADMINISTRATION: Nurses checks placement and patency by: If you hear this sound, gently draw back on the piston of the syringe. The appearance of gastric contents implies that the tube is patent and in the stomach. If no gastric contents appears, the tube may be against the lining or the tube may be obstructed. On 03/04/2020 at 1:00 p.m. an observation of medication administration with Staff C, Licensed Practical Nurse (LPN), who works on the West Low Hall, was conducted with Resident #48. Staff C, (LPN) put a stethoscope to the resident's stomach and stated, I hear the swoosh (air). Staff C (LPN) did not follow standard nursing practice and technique, which is to check residual volume in Resident #48's GT before administering the 01:00 p.m. medications. Staff C (LPN) was observed administering the following 01:00 p.m. medications: [REDACTED]. -[MEDICATION NAME] HCL Tablet 2.5MG Give 1 Tablet via [DEVICE] (GT) three times a day for [MEDICAL CONDITION]. According to Nursing 2020 (https://journals.lww.com/nursing/Fulltext/2004/ /Measuring_gastric_residual_volume.17.aspx) Release the GT clamp. To verify tube placement and patency, aspirate for gastric contents, note the residual volume, and follow your facility's policy for reinstalling it. Clamp the GT, remove the syringe, and take out the plunger. Further continuation of the observation Staff C (LPN) re-started enteral feed of [MEDICATION NAME] 1.2 @ 81 ml/hr rate which gets turned at 12:00 p.m., after being shut off at 6:00 a.m. on the prior 11:00-7:00a.m. shift. During an immediate interview with Staff C (LPN) at 1:30 p.m., he confirmed the medications for Resident #48 were administered before checking the resident's residual volume in the GT and stated I checked placement this morning when I gave the 09:00 a.m. medications, and I don't have to check residual again. A record review for Resident# 48 indicated he was initially admitted on [DATE] and re-admitted on [DATE] with multiple [DIAGNOSES REDACTED]. A review of active physician orders [REDACTED].@81ml/hr rate X 18 hour down at 6:00 a.m., Start Tube Feed (TF) on at 12:00 p.m., and check residual every shift and record quantity. If more than 60 ml hold feeding for 1 hour and notify MD every shift. During an interview with the Director of Nursing (DON) on 03/04/2020 at 3:52 p.m., he was informed of observations made of Resident #48's medication administration, and that the resident's GT was not checked first for residual. The DON was also informed that the Enteral Feed was started after 1:00 p.m. by Staff C (LPN). The DON stated Q shift is when we check for residual, I checked with the nurse earlier and he said he checked the residual in the morning during the 09:00 a.m. medication administration. The DON was also asked what the facility's policy is regarding nursing best practices for residual being checked in a [DEVICE], before medication administration. Further information was not provided by the DON regarding the question. On 03/04/20 at 4:46 p.m., a random interview was conducted with Staff D, (LPN) who works the 3:00-11:00 p.m. shift on the West Low Hall. Staff D was asked what the facility policy was for when you would check residual for a Resident #48's GT, and what the facility policy was? Staff D (LPN) stated You mean if it's been off for like four (4) hours for enteral feed then I do check residual because its been a while. On 3/5/2020 at 12:55 p.m. another random interview was conducted with Staff E (LPN) on the East Hall who was asked what the facility policy was for checking residual for a resident? She indicated that she checks the residual in the GT before she initiates and turns on TF. An interview was conducted with East Wing's Unit Manger (UM), Staff F, on 03/05/20 at 01:06 p.m. The UM was asked what the facility policy was for checking residual for a resident with a GT? The UM stated Every time you use the tube you check placement by checking residual and when you put the air in and listen to it, you then pull back to check the residual. It is what I do, its standard nursing practice.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** Based on observation, interview and record review the facility failed to appropriately secure loose medications in two (2) of three (3) medications carts. Findings included: A review of the facility's policy Section 3.6 titled, Medication Use: Medication Storage, effective 7/01/2013 with revision date of September 2014, Page 01 of 02, reads: PURPOSE: To provide guidelines for proper storage of medications within the facility. PROCEDURE: Medications will be stored in the original, labeled containers received from the pharmacy. On 03/04/2020 at 4:00 p.m., an observation of the medication cart located on the West High Hall included seven (7) loose tablets in second drawer from the top draw of the medication cart. Staff A, Registered Nurse (RN), confirmed the presence of unsecured and loose medications to be one white/blue tablet, four white tablets, one yellow tablet, and one pink tablet. (Photographic Evidence Obtained.) On 03/04/2020 at 11:04 a.m., an observation of the medication cart located on the Low West Hall included two and a half (2.5) total loose tablets. Loose medications were observed to be in the second draw from the top draw of one gray tablet, yellow and white tablet. The third draw consisted of one (1) loose black tablet in the third draw from the top of the medication cart. Staff B Licensed Practical Nurse (LPN), confirmed the presence of the unsecured and loose tablets. (Photographic Evidence Obtained.) On 03/04/2020 at 5:10 p.m., an interview was conducted with Director of Nursing (DON). The DON was informed of the observations of nine and a half (9.5) loose and unsecured medications. The DON indicated that both Staff A (RN) and Staff B (LPN) informed him of the loose and unsecured tablets in both medication carts. The DON stated, The nurses should check every shift their medication carts and make sure there are no loose pills. He further revealed that nursing staff should also check during mediation administration for the presence of loose and unsecured medications, and if found, nursing staff should immediately destroy them.

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