STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105071	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayside Care Center	811 Jackson St N Saint Petersburg, FL 33705

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, the facility did not ensure the medication error rate was below 5% for two resident (#7 and #83) out of four residents sampled for medication administration. This resulted in 3 errors out of 28 medication administration opportunities for a medication error rate of 10.71%.Findings included:1.) An observation was conducted on 3/17/2026 at 9:30 AM of medication administration with Staff A, Licensed Practical Nurse (LPN). Staff A, LPN was observed preparing and administering the following medications for Resident #7:Cholecalciferol Capsule 25 mcg (microgram) / 1000 units x 1 tabletCranberry Oral Tablet 450 mg (milligram) x 1 tablet Reconciliation of Resident #7's physician orders showed the following orders:Cholecalciferol Capsule 400 UNIT - Give 1 capsule by mouth one time a day for Vitamin D deficiency.Cranberry Oral Tablet 400 MG (Cranberry (Vaccinium macrocarpon)) Give 1 tablet by mouth two times a day for UTI ppx (prophylaxis).An interview was conducted on 3/17/2026 at 9:39 AM with Staff A, LPN. Staff A, LPN said she did not realize the medications were the wrong doses. Staff A, LPN said she should have double checked the bottles before administering the medications.2.) An observation was conducted on 3/17/2026 at 9:12 AM of medication administration with Staff F, LPN. Staff F, LPN was observed preparing and administering the following medication for Resident #83:Metoprolol Tartrate 25 MG Tablet x 0.5 tabletReconciliation of Resident #83's physician orders showed the following orders:Metoprolol Tartrate 25 MG Tablet - Give 0.5 tablet by mouth two times a day for htn (hypertension) hold for sb (systolic blood pressure) less than 100mmHg (millimeters of mercury) or diastolic blood pressure less than 60mmhg.A record review of Resident #83's vital signs showed on 3/17/2026 at 7:17 AM the resident's documented blood pressure was 106/58.An interview on 3/17/2026 at 9:27 AM with Staff F, LPN, was conducted. Staff F, LPN said that she takes all her resident's vital signs in the morning before medication administration. Staff F, LPN said the blood pressure was outside the parameters and she should not have given that medication.An interview on 3/17/2026 at 2:00 PM with the Director of Nursing (DON) was conducted. The DON said the nurse should have double checked the dosage before administering the medication to Resident #7. The DON said the metoprolol for Resident #83 should have been held according to the physician order.A review of the policy revised in April 2019, titled, Administering Medications, revealed Medications are administered in a safe and timely manner, and as prescribed. 4: Medications are administered in accordance with prescriber orders.10: The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage.before giving the medication.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records review, and interviews, the facility failed to ensure dignity was maintained related to incontinence needs for one resident (#65) out of four residents observed.Findings included: On 03/17/2026 at 09:59 AM, an observation was made of Resident #65 lying in bed. Resident #65's left leg was in a triangle position, with the knee pointing up. An observation was made of a brown mushy substance with a stool-like appearance, on Resident #65's lower left buttock area. The brown matter was between Resident #65's left buttock and the shorts. Resident #65's room had a strong odor that smelled like feces. Resident #65 stated having knowledge when he had a bowel or bladder movement. Resident #65 stated he was waiting for staff to clean him up. Resident #65 did not say if he had utilized the call light. Resident #65 said staff would go on breaks for an hour with no coverage in place, resulting in delays in being changed.On 03/17/2026 at 10:35 AM, at 10:58 AM, at 11:15 AM, and at 12:00 PM, the same observation was made of Resident #65 lying in bed with the brown matter on the left buttock area and the strong odor of feces was noted.During an interview and observation on 03/17/2026 at 12:00 PM, Staff J, Certified Nursing Assistant (CNA), observed Resident #65 in bed and confirmed the resident had a bowel movement on the left buttock. Staff J stated she was not the assigned CNA and would notify the resident's aide. Staff J left to find Resident #65's aide.During an interview on 03/17/2026 at 12:57 PM, Staff K, CNA, stated not knowing Resident #65 needed to be changed. Staff K stated having given the resident coffee between 11:00 AM and 12:00 PM and stated no odors were noticed at the time. Staff K stated not looking at Resident #65 visually to identify if there were any care needs. Staff K stated she expected Resident #65 to let her know when he needed to be changed.Review of Resident #65's medical records revealed the resident was admitted to the facility on [DATE]. Resident #65 had medical diagnoses to include chronic kidney disease, End stage renal disease, chronic pain and major depressive disorder.Review of Resident #65's Minimum Data Set (MDS), dated [DATE] section C, revealed a Brief Interview Mental Status (BIMS) score of 15, indicating cognition was intact. Section GG revealed for toileting hygiene, the resident was rated a 1, meaning the resident needed the helper to do all the effort during care. Section H revealed Resident #65 was frequently incontinent for bladder and bowel.Review of Resident #65's care plans revised on 01/28.2026 revealed a focus: Resident #65 was incontinent of bowel and bladder and required assistance with incontinence and toileting care, initiated 03/11/2025. The goal was for Resident #65 to be clean, dry, and odor free daily through the next review date. The Interventions included to provide assist with incontinence care and observe for the presence of stool.During an interview on 03/17/2026 at 01:04 PM, Staff A, Licensed Practical Nurse (LPN), stated CNAs should check on residents every two hours. Staff A stated CNAs should look at residents visually to check for care needs. Staff A stated Resident #65 lying in bowel movement for two hours should have been identified by the CNA. Staff A stated, that's unacceptable.During an interview on 03/19/2026 at 11:38 AM, Resident #65 stated he was being made to wear diapers by staff, because they hold it better. The resident stated being embarrassed about the situation and having preferred briefs.During an interview on 03/19/2026 at 11:55 AM, Staff B, LPN, Unit Manager (UM), stated Resident #65 was frequently incontinent of bowel and sometimes would not know when a bowel movement had been made. Staff B stated staff should not fully rely on residents to make care needs known and should have used other methods to identify Resident #65's care needs. Staff B stated Resident #65 wore diapers. During an interview on 03/19/2026 at 10:38 AM, the Director of Nursing (DON), stated staff were expected to check on residents every two hours. The DON stated staff were expected to ask Resident #65 if incontinent care was needed. The DON stated the staff should use visuals and smell for odors to identify incontinent care needs. The DON stated, That's just common sense. Review of a facility policy titled Quality of Life - Dignity, dated 2020, revealed:Policy Statement - Each resident shall be (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem.Policy Interpretation and Implementation11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. For example: b. Promptly responding to a resident's request for toileting assistance.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure the Preadmission Screening and Resident Reviews (PASARRs) for residents with a mental disorder and individuals with intellectual disability with qualifying mental health diagnosis, were updated and accurate, and failed to submit recommendations for a level II PASARR for two residents (#4 and #63) of two residents reviewed.Findings included: Review of Resident #63's admission record revealed the resident was admitted on [DATE] and readmitted on [DATE]. The record included diagnoses not limited to bipolar disorder, current episode, manic, without psychotic features (onset 3/19/2025), major depressive disorder, recurrent, moderate (onset 3/19/2025), generalized anxiety disorder (onset 3/19/2025), primary insomnia (onset 3/19/2025), unspecified dementia unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (onset 6/21/2022). A review of Resident #63's psychiatric notes dated 2/18/2026, revealed the resident is stable on psychiatric medication. Resident #63 had diagnosis of Bipolar disorder, Major Depressive Disorder (MDD), Recurrent Generalized anxiety disorder, Dementia without behavioral disturbance and Insomnia: A review of Resident #63's Minimum Data Set (MDS), dated [DATE] for Medications, revealed the Resident is taking an antidepressant and anticonvulsant regularly. Review of the Level 1 PASARR dated 12/27/2023 and completed by an acute care facility revealed in Section I: Bipolar disorder, schizoaffective disorder, and insomnia were marked under Section A Mental Illness (MI) or suspected MI. Depressive disorder anxiety disorder were not marked. Section II: Other Indications for PASARR Screen Decision-Making questions 1 through 7 were marked no. Section III: PASARR Screen Provisional admission or Hospital Discharge Exemption Not a provisional Admission was marked no. Section IV: PASARR Screen Completion, Individual may be admitted to an Nursing Facility (check one of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated. The review showed a level II PASARR was not submitted for consideration. On 3/19/26 at 11:55 a.m., an interview was conducted with the Director of Nursing (DON). She reviewed Resident #63's electronic health chart and confirmed the resident had diagnoses of anxiety and depression, in addition to the diagnoses that were marked in Section I. She stated the anxiety and depression diagnoses should have been marked but were overlooked. The DON stated she did not submit a Level II for the resident because the system did not trigger a Level II. The DON stated she depends on the system to trigger a Level II for residents. Review of Resident #4's admission record revealed an admission date of 12/11/2024 and initial admission of 05/07/2021. Resident #4 was admitted with diagnosis to include paranoid schizophrenia, bipolar disorder, current episode depressed, mild, epilepsy, unspecified, major depressive disorder, recurrent, unspecified and generalized anxiety disorder. Review of Resident #4 Psych note dated 02/02/2026 revealed, assessments and plan. rationale behind diagnosis Schizophrenia (confirmed diagnosis), the patient has chronic and consistent (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychosis. These symptoms cause significant distress and functional impairment to the patient. The resident had diagnosis of Bipolar disorder, Major, Depressive Disorder, recurrent and Generalized anxiety disorder. Review of Resident #4's Level I PASARR, dated 03/18/2026, revealed questions 1 thru 7 were all marked no. Section III. PASARR screen is not a provisional admission was marked. Section IV. PASARR screen completion, no diagnosis or suspicion of serious mental illness or intellectual disability indicated. The review showed a level II PASARR was not submitted for consideration. During an Interview on 03/19/2026 at 11:55 a.m., the Director of Nursing (DON) stated on admissions the resident comes from the hospital with a PASARR. We go through the diagnosis and see if they have diagnosis like depressions and anxiety and add it to the PASARR. We also have psych see them to confirm the diagnosis. I know if a resident needs a level II by the information I added to the form. The form tells me if I need to submit for a level II for residents. I have not submitted any level II's for any of our residents. When I did Resident #4's PASARR it did not trigger me for a level II. Yes, she has diagnosis of schizophrenia and depression, in the past I know they would have triggered, but this time it did not. I am depending on the system to trigger me to do a level 2. Questions 1 thru 7 say no because when I read the statement it does not apply. Residents are currently not having symptoms. If resident with multiple mental illness diagnosis need a level two then there is a lot of residents who may need a level II here. A review of the Administration-PASSAR policy, revised 12/26/2025, revealed the facility will ensure each resident in a nursing facility is screened for a mental disorder (MD) or intellectual disability prior to admission and individuals identified with MD or ID are evaluated to receive care and services.If the PASARR Level I outcome is positive (indicating a possible serious mental illness, intellectual disability, or a related condition) then a PASARR Level II evaluation and determination must be completed prior to a nursing home admission. An individual in considered to have a serious mental illness (MI) if the individual meets the following requirements on diagnosis, level of impairment and duration of illness Diagnosis. The individual has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders. This mental disorder is: A schizophrenic, mood, paranoid, panic, other severe anxiety disorder, somatoform disorder, personality disorder, other psychotic disorder, or another mental disorder that may lead to a chronic disability.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who smoked followed the facility's smoking rules/policies regarding observed loose smoking items inside the facility, and residents smoking unsupervised within the facility's parking lot, for three residents (#51, #32 and #30) out of thirty-four residents reviewed, during two days (3/16/2026, 3/18/2026) of four days observed. Findings included: Review of the facility's resident admission packet acknowledgement documents revealed a document titled, Resident Smoking Policy: Infraction notification, signed by Resident #51, #32 and #30 showing, [Name of Facility] maintains a smoke free environment. Smoking is, therefore, prohibited in any interior space, including . Parking and Driveway areas, or any other common area not designated as a smoking area. On 3/16/2026 at 10:30 a.m. an observation of the facility's parking lot revealed three male residents #51 and #32 and an unknown resident huddled up in between two cars and were observed smoking cigarettes, within the facility property. The residents were observed with their own cigarettes and smoking lighting devices. There were no staff observed outside with these residents, who were smoking on facility property. On 3/16/2026 at 1:00 p.m. Resident #51 was observed in his room. During the interview, he revealed he did smoke and either goes out in the smoking area to smoke, or signs himself out on Leave of Absence (LOA) to leave the facility to smoke. Resident #51 revealed the facility kept his cigarettes and he checked them out from the smoking supervisor out in the smoking porch. He stated he holds his cigarette lighter and takes it with him when he leaves the building. Resident #51 then picked up a clear yellow lighter from off his bedside dresser and presented it for observation. The lighter had fluid inside. Resident #51 revealed he knew he was supposed to check the lighting device in to the smoking supervisory staff prior to and after he was done smoking. Resident #51 stated it was easier that he kept his lighting device rather than to check it in and out all the time. Review of Resident #51's medical record revealed he was admitted to the facility on [DATE] with a primary diagnosis of Post Traumatic Stress Disorder (PTSD). Review of Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed; a Brief Interview Mental Status(BIMS) score of15 out of 15, which indicated intact cognition. Review of the most current smoking assessment for Resident #51 dated 3/23/2023 revealed; Resident assessed as being able to smoke independently or with set up. Section 03(c) maintenance of smoking materials did not indicate if resident maintains or if facility maintains. Review of the 3/16/2026 Nursing Quarterly Comprehensive Evaluation, smoking evaluation section revealed; not scored, revealing Resident #51 scored (0), which indicated Resident #51 was a safe smoker. Review of the current care plans with a next review date 6/6/2026 revealed focus – Resident #51 desires to smoke. Resident has been assessed as able to smoke independently. Resident has been informed of the facility smoking policy. The interventions revealed: Monitor for signs of unsafe (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoking practices. Provide assistance with lighting cigarette in resident - designated smoking area. Maintain smoking materials in designated area. Provide redirection if resident is observed in any unsafe smoking practices. Seek the assistance of managers/supervisors if needed. On 3/16/2026 at 10:30 a.m. and on 3/18/2026 at 9:50 a.m. Resident #32 was also observed to have his personal cigarette lighting device on his person when visited in his room. During the interview, the resident did not want to comment on why he had his own smoking lighting device while in his room. On 3/17/2026 at 10:00 a.m. and 3/18/2026 at 10:30 a.m. Resident #32 and two other unknown residents were observed in the same place in the parking lot back behind the facility, smoking within facility property, and without staff supervision. Review of Resident #32's medical record revealed he was admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD) and Nicotine Dependence, Cigarette use. Review of the Annual MDS assessment dated [DATE] revealed Resident #32 had a BIMS score of13 of 15 which indicated intact cognition. Review of the Nursing Quarterly Comprehensive assessment dated [DATE] revealed; Section for smoking = Total score of 0, which indicated Resident #32 was deemed a safe smoker. Review of Resident #32's current care plans with a target date of 6/12/2026 revealed Resident #32 desires to smoke. Resident has been assessed as able to smoke with supervision. He has been informed of the facility smoking policy. Interventions included: Monitor for signs of unsafe smoking practices. Return smoking material to designated staff upon re-entry to the facility from LOA. Maintain smoking materials in designated area. Review of Resident #32's Safe Smoking Agreement, signed by the resident on 9/12/2025 revealed rules to include: Keep all smoking paraphernalia (cigarettes, lighters, e cigarettes etc.) secure, with our smoking aide. Residents may not have any smoking paraphernalia on them at any time per center for resident and center safety; Residents will only smoke in designated area and this is the courtyard only. If resident has an LOA they must sign out and sign back in with their nurse. During a tour of the facility on 03/16/2026 at 10:10 a.m., Resident #30 was observed with a red transparent lighter on his bedside table. Resident #30 explained having taken the lighter the night before and had not mentioned it to the staff. Resident #30 stated sometimes he kept the lighter.Review of Resident #30's medical record revealed the resident was admitted to the facility on [DATE] with a diagnosis of COPD. Review of Resident #30's Minimum Data Set, dated [DATE], section C revealed a BIMS score of 15 out of 15 meaning the resident was cognitively intact of 15, which indicated cognition intact. Review of Resident #30's care plans revealed a focus - Resident #65 desires to smoke. Resident #65 has been assessed as able to smoke independently. Resident #30 has been informed of the facility smoking policy, initiated 10/16/2025. The goal was for Resident #30 to adhere to the smoking policy daily through the next review date, revised 01/12/2026. Interventions included to monitor for signs of unsafe smoking. Return smoking material to designated staff upon re-entry to the facility from leave of absence. Provide redirection if resident is observed in any unsafe smoking practices. Seek the assistance of managers and supervisors if needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/18/2026 at 1:31 p.m. an interview with the smoking attendant aide, Staff G. Staff G reported he keeps all cigarettes and lighters for current smoking clients locked in smoking cart. Staff G stated he handed each resident one cigarette at a time. He stated he would light it for the residents. Staff G reported he had a list of current residents who require assistance and a smoking apron is provided during smoking. Staff G stated the nursesassess new residents for safety. Staff G stated when residents leave on LOA they are provided with their smoking lighters and they are to check them back in to put in the cart after they return to the facility. Staff G confirmed when residents leave on LOA to smoke, they must leave the facility property, to include the parking lot. Staff G revealed he had seen residents in the back parking lot smoking and stated he told them they must leave the property to smoke. Staff G stated having spoken with the management regarding those observations. On 3/19/2026 at 2:30 p.m. an interview with the Nursing Home Administrator (NHA) confirmed the facility allows for residents to have smoking activities in designated areas, which included the inner courtyard, an open space and with shade. The NHA stated they have general smoking times and there is always a staff member to assist and supervise them. The NHA stated the smoking supervisor has been trained and educated on the smoking rules and policies and will man a cart outside where all the cigarettes and smoking lighters are locked up. The NHA revealed himself, the activities staff and the social worker will go to the store to purchase the resident's cigarettes. However, there are residents who are able to and check themselves out on Leave Of Absence (LOA), and they purchase cigarettes out in the community and bring them back. He stated that residents who do bring cigarettes back to the facility have to give them to staff so they can be locked up in the smoking activities/supply cart. The NHA stated for resident smokers who signed out LOA, they can go to the smoking supervisor and check out their cigarettes and lighting devices, and they must sign out and leave the property to smoke. The NHA stated those residents should be leaving the entire property, including the parking lot. The NHA confirmed he did know there has been times when several residents would check out LOA and loiter in the end of the parking lot, or the back of the facility parking lot and smoke there. The NHA stated he has educated residents and staff to ensure they leave the entire property. He confirmed that some residents who leave on LOA will at times bring back smoking lighting devices and keep them on their person or in their room. He said unfortunately there are residents that still try to keep lighting devices on their own. Review of the undated facility smoking policy revealed it is the policy or this facility to establish and maintain safe resident smoking policies. in accordance with resident's rights and preferences and in accordance with Life Safety Code requirements and state and local laws governing safe practices for the facility.Procedure: Prior to, or upon admission, residents shall be informed in writing and sign acknowledgment that smoking is permitted in designated areas only, and that smoking articles of any kind arc to be; stored at the nursing station (or area designated by the facility) and not permitted to be stored in residents sleeping or living quarters.All residents will be evaluated by licensed nursing staff regarding smoking preferences upon admissions, quarterly, and with a significant change in resident mental or physical condition. All residents who smoke will be further evaluated for risk factors, responsibility, and will be orientated to smoking areas and procedures. Any Resident that goes LOA will be requested to turn in any smoking articles or paraphernalia.Smoking Articles:All residents who smoke will not be permitted to keep any smoking articles/paraphernalia in their room or on their person, this includes but is not limited to the following: cigarettes, lighters of any kind, matches .Lighter Fluids, 'to include butane gas, or any other forms of gas or fluids shall not be retained by the resident at any time, either in his/her possession or within his/her living or sleeping areas. Photographic evidence obtained.

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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. Based on observations, interviews, and record review, the facility did not ensure 1. Medications were stored safely and out of the residents' reach for one resident (#19) out of three residents observed, and in one medication cart (West High) of 3 medication carts observed; 2. Did not ensure expired medications were discarded in one medication cart (West High) of two and in one medication room (East) of two medication storage rooms and 3. Did not ensure chemicals were not stored with wound care supplies in one storage room (East) of two observed.Findings included:1. An observation on 3/16/2026 at 9:26 AM of Resident #19 revealed two medications at bedside, antiseptic mouth rinse and ammonium lactate 12% lotion. The resident was not in room at the time. A follow -up interview and observation was conducted on 3/16/2026 at 12:35 PM with Resident #19. The observation revealed the same medications still at bedside. Resident #19 said he won the antiseptic mouth rinse at bingo a few weeks ago. He did not speak of the ammonium lactate lotion.An observation was made on 3/16/2026 at 2:45 PM of the residents playing bingo. Underneath the cart holding the bingo balls on the second shelf, was 2 bottles of antiseptic mouthrinse.An interview on 3/16/2026 at 2:46 PM with Staff E, Certified Nursing Assistant (CNA)/Activities Assistant was conducted. She said the stuff on the cart's second shelf was prizes for the residents that they win during bingo. This cart was left unattended periodically and accessible to all the residents participating in the game.An observation on 3/16/2026 at 9:47 AM of the [NAME] High medication cart revealed two boxes of inhalation medications. The cart was observed unattended in a hallway where everyone was walking through to include residents and guests.An interview was conducted on 3/16/2026 at 9:49 AM with Staff D, LPN, Unit Manager. She said the inhaled medications should not be on the top of the medication cart. She said she did not know where the nurse was.2. An observation on 3/16/2026 at 12:20 PM of the [NAME] High medication cart revealed an unopened insulin pen with a label, refrigerate on the box and two inhalers that were opened with no date as follows: Budesonide and formoterol fumarate dihydrate inhalation aerosol 120 inhalations, 113 remaining. Fluticasone Propionate and Salmeterol inhalation powder - 60 inhalations, 54 remainingAn observation on 3/16/2026 at 12:20 PM of the [NAME] High medication cart revealed three expired medications as follows: Bisacodyl 5mg - expired 2/2026 CoQ10 100mg - expired 2/2026 Carisoprodol 250mg Tablet - expired 2/6/2026An interview on 3/16/2026 at 12:30 PM with Staff C, Licensed Practical Nurse was conducted. She verified the Bisacodyl 5mg and CoQ10 100 mg were expired. Staff C said the insulin pen should have been stored in the refrigerator since it was not opened yet. She said she does not know why the inhaled medications were not labeled.An observation on 3/16/2026 at 1:50 PM of the East Side Medication Storage Room refrigerator revealed a box labeled, Avonex. Inside the box was two sealed syringes that expired on 11/2025; bleach wipes, and a box of bisacodyl suppositories which had expired in 10/2025. The bleach wipes and the bisacodyl suppositories were stored on the same shelf with no divider. On the shelf above the oxygen tanks there was a box of nicotine transdermal packages that expired in 11/2025, and a box of nicotine lozenges that expired on 1/2025, Gvoke hypo pen (for low blood sugar emergency) expired in 12/2025, and a bottle of elder tonic that expired in 1/2026.An interview was conducted on 3/16/2026 at 2:05 PM with Staff B, LPN Unit Manager. She said all the nurses are responsible for cleaning the medication rooms. She said she and the DON (Director of Nursing) would go behind and assure the medication rooms are cleaned and there are no expired medications. She verified the medications were expired and did not know why the medications were in the medication room.3. An observation on 3/16/2026 at 2:13 PM of the East Side Wound Care Cart revealed in the bottom drawer a container of bleach wipes laying over and was stored with wound care supplies. The wound care supplies were not opened. An interview on 3/16/2026 at 2:15 PM with Staff A, Licensed Practical Nurse was conducted. She said she thought the bleach and the supplies (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105071	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could be stored together.An interview was conducted on 3/17/2026 at 2:00 PM with the DON. The DON said the nurses are responsible for cleaning and checking for expired medications. She said the unit managers should have been checking the medication carts and storage rooms. She said the expired medications should have been discarded. She said medications should not be at the residents bedside. She said she was unaware that antiseptic mouth rinse was being given to residents as gifts after winning Bingo. She said a lot of residents that reside in the facility have a history of alcohol or drug abuse.An interview on 3/19/2026 at 3:25 PM with the NHA was conducted. He said the nursing staff was responsible for cleaning the medication rooms and carts. He said the medications should have been discarded. He said the mouth rinse should not be given to the residents and left unsecured at the bedside table.A record review of the policy revised in 2/2023 titled, Medication Labeling and Storage, the policy heading The facility stored all medications and biologicals in locked compartments.; 2: The nursing staff is responsible for maintaining medication storage; 3: If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items; 6: Medications requiring refrigeration are stored in a refrigerator located in the medication room; (Photographic Evidence Obtained)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, records review, and interviews, the facility failed to follow contact isolation precaution protocols in one room (9) out of one room observed with contact precautions.Findings included: On 03/19/2026 at 01:20 PM, Staff I, Certified Nursing Assistant (CNA), was observed entering room [ROOM NUMBER], without a gown or gloves. On 03/19/2026 at 01:21 PM, Staff F, Licensed Practical Nurse (LPN), was observed entering room [ROOM NUMBER], without a gown or gloves.An observation of the room's door revealed a Contact Precaution sign on it. with the words STOP in red. The sign revealed: everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also; Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care or more than one person.During an interview on 03/19/2026 at 01:21 PM, Staff I, CNA, stated gown and gloves were only needed for contact precaution signs, and when making contact with the resident. Staff I stated the contact precaution sign on room [ROOM NUMBER]'s door was for B bed and stated, I just know. Staff I stated the contact sign did not specify the bed it was assigned to, in order to protect the residents' identity. Staff I reviewed the caution sign and stated gown and gloves were not needed before entering room [ROOM NUMBER], because contact was not made with the resident.During an interview on 03/19/2026 at 01:26 PM, Staff F, LPN, stated that gown and gloves were only needed for contact precaution signs, and when making contact with the resident. Staff F stated not having donned a gown, because contact was not made with a resident in room [ROOM NUMBER]. Staff F confirmed room [ROOM NUMBER] had a contact precaution sign and that it required gown and gloves prior to entry. Staff F stated having gone into room [ROOM NUMBER], without gown and gloves, because medication was provided to a resident and no contact was made with the resident.During an interview on 03/19/2026 at 1:56 PM, the Director of Nursing (DON), who was also the Infection Preventionist (IP), stated rooms with contact precaution signs, required gloves, gown, and mask if respiratory, prior to entry. The DON/IP stated precaution signs should have corresponding resident bed identifiers on them. The DON/IP stated staff were getting enhanced barrier precautions and contact precautions mixed up. The IP stated the actions of the staff were not appropriate. Review of an undated facility policy titled, Infection Prevention and Control Program revealed: Policy Statement- An infection prevention and control (IPC) program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.Surveillance:2. Process surveillance collects data that indicates adherence to infection prevention and control practices, for example:a. hand hygieneb. appropriate use of PPEc. appropriate use of, and procedures during, transmission-based precautions. f. Infection control practices during resident care. (Photographic evidence obtained)