STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105477	A. Building B. Wing	04/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Pointe Nursing Pavilion	4201 31st St S Saint Petersburg, FL 33712

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 - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record reviews and interviews the facility failed to ensure shift to shift controlled substance logs were complete and accurate for five hall logs (100, 300, 400, 500, and 600) out of six controlled substance logs reviewed. Findings included: On 4/8/26 at 9:12 a.m. during an observation, interview and narcotic count verification of the 400 Hall even cart with Staff A, Licensed Practical Nurse (LPN), the controlled substance key exchange audit (CSKEA)form used to document controlled medications and medication cart key exchange was noted blank. There were no signatures by the off going or oncoming nurse. Staff A, LPN said controlled medications were counted at the beginning of the shift and stated she did not sign the form. Staff A, LPN was also assigned to the 300 Hall cart, and the CSKEA form was not signed. Staff A, LPN was observed signing the oncoming nurse column. On 4/8/26 at 9:51 a.m. during an observation, interview and narcotic count verification of the 400 Hall odd and 500 Hall carts with Staff B, Registered Nurse (RN). Staff B, RN had signed the CSKEA form for the count with the oncoming 3:00 p.m. to11:00 p.m. nurse. In response to when the form should be signed, Staff B, RN said I should sign at the end of my shift, my mistake, I should not have done that.On 4/8/26 at 9:57 a.m. during an observation, interview and narcotic count verification of the 100 Hall even and 600 Hall carts with Staff C, LPN. The CSKEA forms were not signed at the beginning of the shift. Staff C, LPN said the count had been completed and she forgot to sign the form. During the count verification for the 600 Hall medication cart Staff C, LPN said there were 40 cards, but 41 cards were present during the verification count. In response to the discrepancy, Staff C, LPN said she received a controlled medication card on 4/7/26 and forgot to add it to the log. An observation of the bubble packs found 8 punctured, torn or taped packs on the 100 Hall even cart and 2 on the 600 Hall cart. Staff C, LPN said she checks the bubble packs for tampering during the narcotic count. In reference to non-intact bubble package, she said it does not appear to be tampered with because, the pills are in there.On 4/8/26 at 10:37 a.m. during an observation, interview and narcotic count verification of the 100 Hall odd and 200 Hall carts with Staff D, RN, she said the CSKEA on both carts were not signed because the count was interrupted by a resident emergency. Staff D, RN was observed signing the oncoming nurse column on both logs. On 4/8/26 at 2:25 p.m. during an interview with Staff E, LPN, Unit Manager (UM) said during shift change the nurses are expected to count controlled medications and both nurses sign the CSKEA form. Staff E said the nurses should observe front and back of the bubble packs to make sure the packaging was intact. She said the pills should not be secured by tape. Staff E stated if the bubble pack was not intact, two nurses are expected to waste the medication.On 4/8/26 at 3:32 p.m. during a telephone interview, the Medial Director (MD) said controlled substance counts must be accurate, and nurses are expected to follow the facility's protocol. The MD said if a bubble pack appears to be tampered with, the nurse is required to follow the established protocol.On 4/8/26 at 3:39 p.m. during a telephone interview, the facility pharmacy services pharmacist said bubble packets that are not intact should be logged and reported to the Director of Nursing (DON). The pharmacist said prior to transporting controlled medications, the cards are checked to make sure they have not been tampered with.On 4/8/26 at 11:00 a.m. during an interview the DON said the oncoming and off going nurses are expected to sign (continued on next page)

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the controlled medication key exchange form when the count is completed. The DON stated the medications should be stored in packages that are not damaged. She said if the bubble packs were not intact, two nurses are expected to waste the medication. On 4/8/26 at 5:21 p.m. the DON said each time the key for controlled medications storage drawer is transferred between nurses, the medication cart log requires dual nurse verification at each shift change, including signatures from both the off-going and oncoming nurse, as well as documented verification of the total number of medication cards in the cart. The DON said this process ensures accountability, accuracy, and continuity of care and should be completed. She said new employees are instructed on how to document the use of controlled medications by the orienting nurse. The DON said the medication cart log requires dual nurse verification at each shift change, including signatures from both the off-going and oncoming nurse, as well as documented verification of the total number of medication cards in the cart.A review of March 2026 controlled drug-key exchange audit forms the facility provided showed the following: 100 Hall-Opportunities 86-Missing Signatures (Count) 23-% Missing Signatures 26.7%-Missing Card Count Documentation (Count) 3-% Missing Card Count 3.4% 300 Hall-Opportunities reviewed 67-Missing Signatures (Count) 26-% Missing Signatures 38.8%-Missing Card Count Documentation (Count) 3-% Missing Card Count 4.5% 500 Hall --Opportunities 84-Missing Signatures (Count) 19-% Missing Signatures 22.6-Missing Card Count Documentation (Count) 15-% Missing Card Count 17.9% 600 Hall-Opportunities 82-Missing Signatures (Count)15-% Missing Signatures 18.3%-Missing Card Count Documentation (Count) 9-% Missing Card Count 11.0 %A review of facility policy titled Controlled Medication Storage, dated 1/26, revealed the following: Policy- Medications included in the Drug Enforcement Administration (DEA) or state classification as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations.5. A controlled medication accountability record is prepared when receiving inventory of any controlled substance to establish a record of receipt and disposition in sufficient detail to enable accurate reconciliation .14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal .A review of facility policy titled Controlled Substances, dated 1/26 revealed the following: Policy-'Controlled Medications are substances that have an accepted medical use (medications which fall under U.S. Drug Enforcement Agency (DEA) Schedules II-V), have a potential for abuse, ranging from low to high, and may also lead to physical or psychological dependence. These medications are subject to special handling, storage, disposal, and record keeping at the nursing care center, in accordance with federal and state laws and regulations.Procedures: 2. The Director of Nursing and the Consultant Pharmacist establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.7. At each shift change, a physical inventory of controlled medications, as defined by state/federal regulations, is conducted and is documented on an audit record.8. Current controlled medication accountability records and audit records are kept by the nursing care center. When completed, audit and accountability records are kept on file according to state and federal regulations.(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 observation, record review and interviews the facility failed to ensure medications were stored and labeled in accordance with professional standards. Observations included refrigerated medications stored outside of required temperature controls, medications lacking open dates, and failure to properly dispose of single-dose vials after use in one med cart (600) of six medication carts sampled.Findings Included: On 4/8/26 at 9:57 a.m. during interview, observation and narcotic count verification of the 600 Hall cart with Staff C, Licensed Practical Nurse (LPN). An opened undated vial of Ativan 20mg/10ml (milligram/milliliter) was in the controlled medication drawer. The clear plastic bag containing the vial was affixed with a sticker containing but not limited to, resident's name, medication issue date 9/24/25, medication strength and instructions to keep in the refrigerator. The label on the vial did not have an open or expiration date written on the label and the vial did not contain markings to check the volume of the medication. Staff C, LPN said she knows there is 9.75mls in the vial and showed the controlled drug declining inventory sheet showing on 12/19 at 9:00 a.m. 0.25 ml was administered and 9.75 milliliters remained in the vial. She said she does not know how long the medication had been stored in the drawer and did not respond when asked if the medication should be refrigerated. Staff C, LPN said the medication label should list the expiration date. (Photographic evidence obtained).On 4/8/26 at 3:39 p.m. during a telephone interview in reference to the Ativan 20mg/10ml stored in the medicate cart, the facility pharmacy services pharmacist said the prescription was filled on 9/24/25. She said, I would not expect the vial to be in use at this time. It was a one-time dose, not for multiple doses and has to be stored in the refrigerator.On 4/8/26 at 11:00 a.m. during an interview with the Director of Nursing (DON) regarding the vial of Ativan 20mg/10ml found in the 600 Hall medication cart, she said, Should have been wasted a long time ago.A review of facility policy titled Controlled Medication Storage, dated 1/26 revealed the following: Policy- Medications included in the Drug Enforcement Administration (DEA) or state classification as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal, state and other applicable laws and regulations.4. Controlled medications requiring refrigeration are stored within a separately locked, permanently affixed box within the refrigerator. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.14. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal .15. Medications awaiting destruction that cannot be disposed of immediately should be recorded on a log to include the name of the individual(s) storing the medication, resident name, the prescription number if applicable, the quantity of the medication, the strength of the medication and the date of disposition. These medications should be stored in a secured area separate from active orders .