STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105846	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baya Pointe Nursing and Rehabilitation Center	587 SE Ermine Ave Lake City, FL 32025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to maintain accurate and complete records for 1 (Resident #1) of 3 residents reviewed.Findings include:Review of Resident #1's Discharge summary dated [DATE] documented the discharge location name and address as Resident #1's home address/his Responsible Party/Daughter's home address. There was no documentation of Resident #1's name or that of his Responsible Party/daughter in the section designated for Resident/Representative Acknowledgement.Review of Resident #1's social worker progress note dated 4/23/2026 read, Resident stated that he would like to discharge home to address [an address not listed on Resident #1's admission record] on 4/23/26. Resident stated that brother [name of brother] will be picking him up from the facility.During an interview on 5/26/2026 at 12:54 PM, the Director of Social Work stated, He [Resident #1] wanted to leave and he didn't trust his daughter. I opened the discharge assessment [Discharge Summary] and put the address [of where the resident is going after discharge].During an interview on 5/26/2026 at 2:02 PM, Staff A, Licensed Practical Nurse (LPN) Unit Manager, stated, He [Resident #1] left with his brother on 4/24 [2026]. I do not remember the brother's name. I think it's on the discharge summary. I remember asking his address. I remember cross-referencing the address on the facesheet with [Resident #1's name]. I couldn't tell you which brother he left with.During an interview on 5/26/2026 at 2:26 PM, the Director of Nursing (DON) stated, It should have been documented where he [Resident #1] went [when he was discharged]. Knowing where a resident is being discharged is required for a safe discharge and is expected to be accurately documented on the Discharge Summary.Review of the facility policy and procedure titled Transfers and Discharges issue in 5/2020 read, Standard: The facility will develop and implement an effective discharge process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care. Procedure: 3. The resident and/or representative (sponsor) will be notified in writing of the following information: c. The location to which the resident is being transferred or discharged .

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105846	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baya Pointe Nursing and Rehabilitation Center	587 SE Ermine Ave Lake City, FL 32025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate and complete clinical record for one (Resident #1) of three residents reviewed for discharge. The discharge documentation contained an inaccurate account of the resident's discharge location and lacked documentation of the resident's discharge disposition and the date and time of discharge.Findings include: During an interview on 5/26/2026 at 12:54 the Director of Social Work stated, He [Resident #1] wanted to leave and he didn't trust his daughter. I open the discharge assessment [Discharge Summary] and put the address [of where the resident is going after discharge]. During an interview on 5/26/2026 at 2:02 PM Staff A, LPN (Licensed Practical Nurse) - Unit Manager stated, He (Resident #1) left with his brother on 4/24 [2026]. I do not remember the brother's name, I think it's on the discharge summary. I remember asking his address. I remember cross-referencing the address on the facesheet with [Resident #1's name]. I couldn't tell you which brother he left with. During an interview on 5/26/2026 at 2:26 the DON (Director of Nursing) stated, It should have been documented where he [Resident #1] went [when he was discharged]. The DON stated that knowing where a resident is being discharged is required for a safe discharge and is expected to be accurately documented on the Discharge Summary. During an interview on 5/26/2026 at 3:45 PM APRN (Advanced Practice Registered Nurse) #2 stated that she remembered Resident #1, and knew his daughter was coming in frequently to visit him. He was a heavy drinker when he was home. She was not in the facility when he left. It was the facility's responsibility to confirm where the resident was being discharged and to ensure everything was safe at home [a safe environment for discharge]. Review of Resident #1's Census Data revealed he was admitted on [DATE] with medical diagnoses that included other sequelae of cerebral infarction; alcohol dependence with alcohol-induced persisting dementia; presence of other vascular implants and grafts; difficulty in walking, not elsewhere classified Review of Resident #1's most recent MDS (Minimum Data Set) Assessment, a Medicare 5-day assessment dated [DATE] documented his BIMS (Brief Inventory of Mental Status) Score as 7 out of 15 which indicated he had cognitive impairment. A Social Worker Progress Note dated 4/24/2026 read, Writer attempted to call [name of Resident #1's brother] in regard to resident being discharged . Writer was unable to reach him. Writer will inform resident. A Social Worker Progress Note dated 4/23/2026 read, Resident stated that he would like to discharge home to address [an address not listed on Resident #1's facesheet] on 4/23/26. Resident stated that brother [name of brother] will be picking him up from the facility. Resident declined home health and equipment. Writer attempted to called POA [Resident #1's daughter's name] to inform her of the discharge and was unable to reach her. Review of Resident #1's Discharge summary dated [DATE] documented the discharge location name and address as Resident #1's home address/his Responsible Party/daughter's home address. There was no documentation of Resident #1's name or that of his Responsible Party/daughter in the section designated for Resident/Representative Acknowledgement. Review of Resident #1's Progress notes from 4/23/2026 through 4/25/2026 revealed there was no documentation of the specific date or time Resident #1 left the facility or any details of his discharge disposition. Review of the policy and procedure titled Transfers and Discharges, with an issue date of 5/2020 read, Standard: The facility will develop and implement an effective discharge process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care. Procedure: 3. The resident and/or representative (sponsor) will be notified in writing of the following information: c. The location to which the resident is being transferred or discharged