

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2025
NAME OF PROVIDER OR SUPPLIER Lakeland Hills Center		STREET ADDRESS, CITY, STATE, ZIP CODE 610 E Bella Vista Dr Lakeland, FL 33805	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22481</p> <p>Based on observations, record review, and interviews, the facility failed to ensure a safe, clean, and comfortable environment for two residents (#7 and #8) of eight sampled residents.</p> <p>Findings included:</p> <p>On 1/14/2025 at 6:55 a.m., Resident #7 and Resident #8's bathroom, connected to their bedroom, was observed with Staff A, Certified Nursing Assistant (CNA). The bathroom had a strong old ammonia and urine smell present. Towels were observed on the floor around the base of the toilet and appeared wet. The toilet seat on the base did not fit on the commode base and was approximately two inches shorter in length than the base. Staff A, CNA stated, the towels have to be put down to soak up water. Staff A, CNA also stated two bedrooms connect to the bathroom with two residents in each room but Resident #7 was the only one who used the bathroom. Staff A, CNA stated Resident #7 has sight challenges but can toilet herself, and she did not want her to slip and fall. (Photographic Evidence Obtained)</p> <p>A review of Resident #7's Admission Record documented an admission in 11/21/2023, readmission in 1/5/2024. Her diagnoses information included but not limited to hemiplegia and hemiparesis following unspecified cerebrovascular disease, muscle weakness, unsteadiness on feet, insomnia, and blindness.</p> <p>A review of Resident #7's Care Plan reflected she was a resident at risk for falls.</p> <p>On 1/14/2025 at 10:00 a.m., Resident #7 was interviewed and confirmed she was able to independently use the bathroom.</p> <p>A review of Resident #8's Minimum Data Set quarterly assessment dated [DATE], documented an admission in 12/29/2021. Section C - Cognitive Patterns documented a Brief Interview for Mental Status score of 15, which indicated she was cognitively intact.</p> <p>On 1/14/2025 at 10:10 a.m., Resident #8 was interviewed and stated she did not use the bathroom. The bathroom door was observed across from her bed. She stated the odor was bad and has lasted a week or more. The resident was observed waving her hand in front of her face and scrunching her nose.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/14/2025 at 11:00 a.m., an interview was conducted with the Housekeeping/Laundry Supervisor. He stated bathrooms should be cleaned daily and if something needs fixed, the housekeeper will tell him, then, he will tell the Maintenance Director by text. If he is in the building, he would go right away and fix the issue. He also stated the facility did not have an electronic work order system.</p> <p>On 1/14/2025, at 12:29 p.m., Resident #7 and Resident#8's bathroom was reviewed with the Maintenance Director. A towel was observed around the base of the toilet. The Maintenance Director confirmed there was something wrong if there was a towel on the floor. He was observed wiggling the base of the toilet and confirmed it was not solid in placement and could be moved. He confirmed the toilet seat on the toilet base was not the right size and smaller than it should be. He also confirmed the toilet had not been in the electronic work order system for him to know it needed repair and he did not know about the toilet. He said he should have been notified of the concern and anyone could have told him about the issue. He also said he cannot do anything about it if he does not know about it.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>22481</p> <p>Based on observations, record review, and interviews, the facility failed to ensure the implementation of the care plan for one resident (#6) of eight sampled residents.</p> <p>Findings included:</p> <p>A review of Resident #6's Admission Record showed an admission of 4/14/2021 with a readmission on 4/20/2023. Resident #6's diagnoses information included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, weakness, and heart failure.</p> <p>On 1/14/2024 at 10:12 a.m., an interview was conducted with Resident #6. Resident #6 stated, I cannot move my left arm. I can't reach the call light. The call light was observed laying on the bed approximately six inches from Resident #6's left arm. She stated, Sometimes I have to scream to get help. I cannot not turn myself.</p> <p>A review of Resident #6's Minimum Data Set quarterly assessment, dated 10/22/2024, showed under Section C - Cognitive Patterns, a Brief Interview for Mental Status score of 13, which indicated the resident was cognitively intact.</p> <p>A review of Resident #6's Care Plan showed a focus area initiated 4/15/2021 and revised on 4/20/2023, ADL (Activities of Daily Living): The resident has an ADL self-care performance deficit. The interventions included call bell within reach while in room/bathroom shower room and remind to use, initiated 04/16/2021 and Bed Mobility: Dependent Assist of 2 to turn and/or reposition, initiated 11/28/2022.</p> <p>On 1/14/2025 at 12:35 p.m., Resident #6 was observed with the facility's Maintenance Director present. Resident #6's call light was observed hanging on the left side of the bed out of reach of the resident. The resident stated she could not reach the call light. The Maintenance Director said he could get a clip for the cord for staff to put the call light in a better position for the resident.</p> <p>A review of the facility's policy & procedure titled Care Plan-Interdisciplinary Plan of Care from Interim to Meeting, effective February 2024, documented the Policy: The facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions.</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep all essential equipment working safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22481</p> <p>Based on observations and interviews, the facility failed to ensure essential laundry equipment was in safe operating condition for one of two industrial dryers, which limited the availability of clean linen for resident care.</p> <p>Findings included:</p> <p>On 1/14/2025 at 6:34 a.m., an interview was conducted with Staff A, Certified Nursing Assistant (CNA). She reported she had about fifteen residents on her assignment. During the interview, she said she did not have enough linen to finish care of her residents. She also said the laundry lady asked her to do the laundry, to put the linens in the washer and the dryer. Staff A, CNA opened the linen closet on 400 hall and said, no towels, no flat sheet, no chuck pads, no washcloths. (Photographic Evidence Obtained)</p> <p>On 1/14/2025 at 6:40 a.m., an interview was conducted with Staff B, CNA. She said, one of the dryers has not been working. When asked if she had enough linen to care for residents, she stated, we have to fight for it.</p> <p>On 1/14/2025 at 6:57 a.m. an interview was conducted with Staff C, Laundry Aide. She reported there were two other laundry aids, Staff D, Laundry Aide and Staff E, Laundry Aide. An observation was conducted of the dryer room of the laundry, which had two industrial sized dryers. One of the dryers had a sign on it, Do Not Put Clothes in Dryer. Staff C, Laundry Aide confirmed one of the two dryers was not functioning and it broke last month.</p> <p>On 1/14/2025 at 11:00 a.m., an interview was conducted with the Housekeeping/Laundry Supervisor. He said the dryer has been down for about 3 weeks. He also said it is an older dryer and there may be a wait time for the parts or the technician to come out. He said the repair was maintenance's responsibility. He stated he verbally warned Staff D, Laundry Aide about having CNAs in the laundry a couple of weeks ago and there should be no one running the machines unless it is the laundry aides. He said, after Staff D, Laundry Aide leaves at 10 p.m., the CNA's started to use the dryers because they did not have enough linens. He also said, usually when Staff D, Laundry Aide leaves, she has to leave the linens in the dryer if they are not dry and the CNA's came in and started the dryer. He said he asked the CNAs about using the dryer and they said they did not have enough linen in the building and they would run the dryer and take what they needed out and leave what was left in the dryer. He said, yes, it definitely slows production to only have one dryer.</p> <p>(continued on next page)</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/14/2025 at 12:06 p.m., an interview was conducted with the Maintenance Director. He stated the dryer stopped working a while ago and he attempted to turn the drum manually, and it would not turn as it should. He stated he put a service call out to the vendor but was not able to state when. He stated the vendor came to the facility on [DATE] and they found a problem with the trunnion bearing assembly, which had failed, causing the drum to lock up and not turn. He also stated the told him they would have to get with the service department and get the parts ordered. He stated around 12/23/2024, he called and left a message and around 12/ 29/2024, two different technicians came out to the facility to diagnose the problem. He said he told the technicians someone else already diagnosed the problem and the technicians looked at the dryer and came up with the same reason for the issue, but they wrote it up and put in the order for the parts. After that, he contacted them, right after the new year and they never told him they were ordering the part. He said yesterday, a package showed up with the part but no paperwork and he is trying to get the technicians out here to put the parts in.</p>		