

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Lakeland Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Lakeland Hills Blvd 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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14161</p> <p>Based on observation of videos posted on social media platforms without consent, review of resident records, policy and procedures review, and staff, family and resident interviews, the facility did not ensure personal privacy and confidentiality for ten of sixteen sampled residents (#7, #8, #9, #10, #11, #12, #13, #14, #15, and #16).</p> <p>Findings Included:</p> <p>Review and observation of videos posted on social media platforms on 8/8/24, 10/2/24, 10/8/24, 12/2/24, and additional dates that could not be determined showed Resident #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16 dancing or in the background of the videos, which also contained various staff members. These videos were recorded in various locations within the facility to include the secure memory care unit and hallways with room numbers where residents resided. Review of the social media videos showed they were originally posted by Staff I, Admissions Coordinator and had been reposted and edited by an unknown number of users on social media. Multiple videos were shown to share the first name of Resident #10 by Staff I, Admissions Coordinator, which was then included into other videos posted by unknown users across various social media platforms. A web browser search using Staff I's social media username showed videos containing Resident #10 with over 406,600 views, 70,600 likes, and 2,456 comments. The original videos were found to be removed; however, they could still be viewed under the search engine preview using Staff I's social media username.</p> <p>Review of the admission record for Resident #10 revealed she had resided in the facility since 2023 and lived in the secure memory care unit during the period the videos were posted. Resident #10's admission record included diagnoses of mood disorder due to known physiological condition with mixed features, dementia in other disease classified elsewhere-severe with mood disturbance, brief psychotic disorder, major depressive disorder - recurrent severe with psychotic symptoms, and anxiety disorder. Review of the annual minimum data set (MDS) assessment completed on 9/28/24 showed a brief interview of mental status score (BIMS) score of 3, indicating severe cognitive impairment. The quarterly MDS completed 12/28/24 also showed a BIMS indicating severe cognitive impairment.</p> <p>A phone interview was conducted with Resident #10's Family Member (FM) on 2/25/2025 at 2:31 p.m. The FM stated she was informed by facility administration around a week and a half ago about videos on [name of social media platform]. The FM reported receiving a call from an unknown nurse a week prior to that, telling her about the videos. The FM stated she would not have consented to Resident #10 being posted on social media and stated, absolutely not.</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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the admission record for Resident #8 revealed she had resided in the facility since 2023 and lived in the secure unit during the period the videos were posted. Resident #8's diagnoses included major depressive disorder -recurrent/moderate, mood disorder due to known physiological condition with mixed features, depression, anxiety disorder, adult failure to thrive, unspecified dementia -unspecified severity, with other behavioral disturbance, and altered mental status. Review of the quarterly MDS assessment completed on 12/27/24 showed a BIMS score of 00, indicating severe cognitive impairment.</p> <p>A phone interview was conducted with Resident #8's FM on 2/25/2025 at 2:19 p.m. She stated she was notified this week of videos being posted on social media, but did not know what social media pages. She was told it was just dancing. She stated no one had contacted her for consent prior to the posting of videos on social media.</p> <p>Review of the admission record for Resident #14 revealed he had resided in the facility since 2022 and lived in the secure unit during the period the videos were posted. Resident #8's diagnoses included metabolic encephalopathy, generalized anxiety disorder, unspecified protein calorie malnutrition, mood disorder due to known physiological condition, and dementia in other diseases classified elsewhere with psychotic disturbance. A determination of incapacity form was signed by the physician on 9/6/2024. Review of the quarterly MDS assessments completed on 10/8/24 and 1/8/2025 showed a BIMS score of 00, indicating severe cognitive impairment.</p> <p>A phone interview was conducted with Resident #14's Health Care Surrogate (HCS) on 2/25/2025 at 12:54 p.m. The HCS stated Resident #14 was unable to give consent due to Dementia and he did not give consent nor was he asked to provide consent for Resident #14 to be posted on social media. He stated he was called this week and told that the videos were on the facility's social media page. He was not told the videos were posted on social media platforms and said he would not have given consent for that.</p> <p>Review of the admission record for Resident #13 revealed she had resided in the facility since September of 2024 and lived in the secure unit when the videos were posted. Resident #13's diagnoses included unspecified dementia, psychotic disturbance, mood disturbance, and anxiety. A physician attestation of incapacity form dated 6/21/24 showed the resident was cognitively unable to communicate a willful and knowing health decision.</p> <p>Review of a quarterly MDS, dated [DATE] showed the resident had short term and long term memory problems and moderately impaired decision making skills.</p> <p>A phone interview was conducted with Resident #13's FM on 2/25/2025 at 1:16 p.m. The FM stated the resident was lucid enough to discuss this matter with.</p> <p>An interview was conducted with Resident #13 on 2/25/2025 at 1:43 p.m. She stated she had not been asked about being on social media postings and did not want to be included on postings. The resident said there was too much information out there, and she wanted to lay low.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the admission record for Resident #7 revealed she had resided in the facility on the secured unit since early 2024. Resident #7's diagnoses included unspecified dementia, mood disorder, anxiety disorder, brief psychotic disorder, and major depressive disorder. An incapacity statement was signed by the physician on 4/5/2024, which showed the resident was incapable of exercising her rights to consent to medical and mental health treatment, to contract, and to make decisions about her social environment or other social aspects of her life. Resident #7's record showed indicated a court appointed guardian was in place. Review of an annual MDS assessment dated [DATE] showed a BIMS score of 00, indicating severe cognitive impairment. Review of Resident #7's record revealed no documentation that her legal guardian consented to the posting of the resident on social media.</p> <p>Review of the admission record for Resident #12 revealed he had resided in the facility's secured unit since October 2024 with diagnoses to include cognitive communication deficit and major depressive disorder, A physician attestation of incapacity form dated 1/10/2025 showed the resident was cognitively unable to communicate a willful and knowing health decision. A significant change MDS assessment was completed 12/16/2024 with a BIMS score of 3, indicating severe cognitive impairment.</p> <p>A phone interview was conducted with Resident #12's FM on 2/25/2025 at 2:48 p.m The family member stated that did not consent to posting videos of the resident on social media. The FM reported she would have expected to be asked for consent prior to any postings on social media.</p> <p>Review of the admission record for Resident #15 revealed she had resided in the facility's secured unit since 2023 with diagnoses to include unspecified dementia with behavioral disturbance, mood disorder, major depressive disorder, and anxiety. A physician attestation of incapacity form dated 8/6/23 showed the resident was cognitively unable to communicate a willful and knowing health decision. Review of the last two quarterly MDS assessments completed 10/12/24 and 1/12/25 showed a BIMS score of 0, indicating severe cognitive impairment. Review of Resident #15's record revealed no documentation of consent for social media video postings. Interview with Resident #15's FM on 2/26/2025 at 11:40 a.m. confirmed he did not provide consent but did not express concerns.</p> <p>Review of the admission record for Resident #9 revealed she was a long term resident of the facility since 2022 and resided on the secured unit at the time of the social media postings. Resident #9's diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A significant change MDS was completed on 11/24/2024 with a BIMS score of 00, indicating severe cognitive impairment. Review of Resident #9's record revealed no documentation of consent for social media video postings. A call was placed to Resident #9's FM on 02/25/2025 at 1:48 p.m. with no answer received. A voicemail was left, but no return call was received.</p> <p>Review of the admission record for Resident #16 revealed she resided in the facility's secured unit since 2023 with diagnoses to include dementia, psychotic disturbance, mood disorder, mood disturbance and anxiety. A physician attestation of incapacity form dated 1/13/2025 showed the resident was cognitively unable to communicate a willful and knowing health decision. A quarterly MDS assessment was completed 1/23/25 with a BIMS score of 10, indicating moderate cognitive impairment. Review of Resident #16's record revealed no documentation of consent for social media video postings.</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the admission record for Resident #11 revealed he resided in the facility's secured unit since 2023 with diagnoses to include unspecified dementia without behavioral disturbance, major depressive disorder, psychotic disturbance, mood disorder, mood disturbance and anxiety. A physician attestation of incapacity form dated 3/18/2022 showed the resident was cognitively unable to communicate a willful and knowing health decision. A quarterly MDS assessment was completed 2/1/2025 with a BIMS score of 6, indicating severe cognitive impairment. Review of Resident #11's record revealed no documentation of consent for social media video postings.</p> <p>An interview was conducted with the Nursing Home Administrator (NHA) and Regional Nurse Consultant (RNC) on 2/24/2025 at 12:50 p.m. The RNC stated she saw a sports reel come across her social media webpage a couple of weeks ago and recognized the facility and Staff I, Admissions Coordinator. The RNC reported informing the NHA. The NHA stated she found videos of the residents posted on a social media platform by Staff I, Admissions Coordinator. The NHA identified Resident #8 and Resident #10 in the videos. The NHA had no knowledge of these videos being posted, and no staff had informed her. The NHA reported staff may have thought Staff I, Admissions Coordinator was filming for activities. The NHA was unaware of other residents posted on social media sites until identified on 2/24/2025. The NHA stated Staff I was suspended and would be terminated on 2/24/2025.</p> <p>Review of the facility's policy titled Social Media Use, implemented 9/1/23 and revised 9/1/24 showed: It is the policy of this company to avoid inappropriate use of social media and to protect the residents, staff, visitors, volunteers and practitioners of this facility against misuse of social media content. Taking, keeping, or distributing unauthorized photographs or recordings of residents through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality. Staff members must recognize that they have an ethical and legal obligation to maintain resident privacy and confidentiality at all times.</p> <p>Policy Explanation and Compliance guidelines:</p> <ol style="list-style-type: none"> 1. Employees are strictly prohibited from transmitting by way of any electronic media any resident-related image or information that may be reasonably anticipated to violate resident rights to confidentiality or privacy. This includes information that could degrade or embarrass the resident. 2. Photographs or recordings of a resident and/or his or her private space without the residents' or designated representatives; written consent, is prohibited. Examples include taking unauthorized photographs/videos of: <ol style="list-style-type: none"> a. A resident's room or furnishings (which may or may not include the resident). b. A resident eating in the dining room. c. A resident participating in an activity in the common area. d. Taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment. <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on interview and policy review the facility failed to ensure an allegations of neglect were reported related to a fall with major injury due to the facility's failure to ensure a safe environment, free from flooring hazards for one resident (#6) of 19 ambulatory residents in the facility's memory care unit.</p> <p>Findings included:</p> <p>Review of a progress note dated 1/20/25 at 12:43 p.m. revealed the resident had an unwitnessed fall in the hallway this A.M. Resident (#6) was observed lying on right side and crying out in pain to lower back and right leg.</p> <p>On 1/20/25 Resident #6 was ambulating in the hallway outside her room and suffered a fall significantly impairing the ability to walk and complete Activity of Daily Living (ADLs) independently. Resident #6 suffered a significant change due to a fractured right femoral head fracture requiring a surgical intervention. The fall which could have resulted in death, caused Resident #6 permanent physical impairment.</p> <p>Review of the Reportable Event Log, dated 1/20/24, revealed events on 1/12/25 and 1/24/25 however neither of the reported incidents included Resident #6's fall with a major injury.</p> <p>During an interview with the Director of Nursing (DON) on 2/25/25 at 2:15 p.m., the DON stated they did not report the incident because Resident #6's fall was not an adverse as the plan of care was followed. She reported the resident who had dementia, was alert and confused, had poor safety awareness, was a long-term care resident residing in the memory care unit.</p> <p>Review of Resident #6's care plan initiated on 8/21/2024 showed a Focus -Resident #6 was at risk for falls related to history of falls, poor safety awareness, incontinence, dementia, psychotropic medication use and neuropathy. An intervention initiated on 8/21/24 showed to Ensure resident has a safe environment: (specify: even floors free from spills and/or clutter; adequate, glare- free light; a working and reachable call light, the bed in low position; hand rails on walls, personal items within reach).</p> <p>Review of Resident #6's admission record revealed the resident was [AGE] years old, originally admitted to the facility on [DATE], with a recent hospital stay from 1/20/25 to 1/26/25. The record showed diagnoses to include a displaced fracture of base of neck of right femur subsequent encounter for closed fracture with routine healing, aftercare following joint replacement surgery, difficulty in walking, presence of right artificial hip joint, and dementia and other diseases classified elsewhere unspecified severity with agitation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Situation, Background, Appearance, and Review (SBAR) evaluation for Resident #6, dated 1/20/25, showed the resident tripped and fell in the hallway, complaining of lower back and right leg pain. The evaluation revealed new pain in the right thigh, lower back and right leg with an intensity score of 9 of 10. The documentation revealed the resident was left in place due to pain on movement, and the primary physician placed an order to send the resident to the emergency room (ER) for evaluation on 1/20/25 at 8:40 a.m.</p> <p>An interview was conducted on 2/27/25 at 9:57 a.m. with Staff E, Licensed Practical Nurse, (LPN). Staff E stated she did not see the resident fall but heard her scream. She stated the resident had suffered a change, she does no walk anymore, does a lot more crying, doesn't eat as much as she used to.</p> <p>Review of the operative report for Resident #6 on 1/21/25 at 9:08 a.m., showed Resident #6 had undergone a right hip hemiarthroplasty. The post-operative X-ray results showed the prosthesis was well-seated with no evidence of hardware loosening or failure.</p> <p>During a facility tour on 2/24/25 at 10:30 a.m. an area of rough and uneven concrete approximately 3ft (feet) x 2 ft in the middle of the corridor of the 200-hall located inside the memory care unit. The uneven concrete area had a drain cap located near the middle that was raised. The concrete area was a known high-traffic area, outside of the secured memory care dining room, the nurses' station, and just outside of Resident #6's room.</p> <p>Review of the Completed Work Order #13601 showed it was created on 12/18/24 at 6:31 p.m. for a 200-hallway clean out cover missing. The order asked, please repair as soon as possible (asap). Please repair drain on 200 hallway asap. The update status on 12/27/24 at 2:49 p.m. showed the Director of Maintenance (DOM) had noted the area set to completed.</p> <p>On 2/25/25 at 9:45 a.m. an interview was conducted with the DOM. He stated on 200-hall, the memory care unit, a resident had pulled the clean-out cap off on 12/18/24. The DOM reported roping the area off and cutting a metal piece to fit on top of the missing cap. He stated this was done after Resident #6 had fallen. The DOM stated the facility had plumbers come in on 1/24/25. The DOM stated from 12/18/24 to 1/24/25, he had put several patches on the area, and went back every day to make sure it was secure and safe. The plumbers removed the tile all the way around the clean out cap, leaving a cemented patch.</p> <p>On 2/27/25 at 2:04 p.m., the Regional DOM reported not being aware of the flooring issue. The Regional DOM stated depending on severity, if something could not be handled in-house the facility contacted vendors for repairs. The Regional DOM expected something to be implemented promptly, within one to two weeks for the safety of the residents.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with the Director of Nursing (DON) on 2/25/25 at 2:15 p.m. She stated Resident #6 had been ambulating in the hallway with a family member (FM) and her foot kind of got stuck on tape. The DON reported the FM grabbed the resident had pulled her, then the resident lost her balance and fell . The DON stated the resident had a history of osteopenia and because of right hip pain the resident was left on floor. The DON stated she interviewed Staff B/CNA, Staff C/CNA, and Staff E, Licensed Practical Nurse (LPN). The DON stated Staff E, LPN was sitting at the desk and did not witness the fall, but heard the resident call out and saw her lying on the right side. The DON confirmed Resident #6 suffered a fall, was transferred out to the hospital, had surgery and came back to the facility. The DON stated Resident #6 had suffered a previous fall on 10/25/24. She stated the resident had a big chair in her room at the time so the family decluttered the room and when the resident started ambulating, the facility ensured the environment was free of clutter and slip hazards to prevent additional falls.</p> <p>An interview was conducted on 2/26/25 at 12:00 p.m. with Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member described the area of concrete as similar to other drains on unit, showing a circular drain with a square metal outer plate. The staff member stated the residents on the unit like to pick at it and had pulled the square metal plate up. Staff J stated the facility had covered the area with an approximately same size metal square and had attached it to floor with yellow and black striped industrial tape so it would be recognized as a caution area. Staff J stated she doubted the residents in the memory care unit, with their BIMS (Brief Interview for Mental Status) scores, would have recognized it as a caution area. The staff member stated the concrete area was a high-traffic area as it was between the dining room, Resident #6's room, and the nursing station. She stated due to it being a dementia unit, they had a lot of residents wandering up and down the hallways. She stated she could only report it to maintenance. Staff J stated the metal and tape were a hazard, and during the repair period the area had become bigger.</p> <p>An interview was conducted on 2/26/25 at 9:38 a.m. with the DON. She reported the findings of the Root Cause Analysis was the resident was ambulating in the hallway, she twisted, the family member took her arm, and her foot was caught on tape, causing the resident to fall. The DON stated she was not sure why the tape was on the floor.</p> <p>On 2/28/25 at 2:55 p.m. an interview was conducted with the NHA. She stated she did a QAPI (Quality Assurance Performance Improvement) on 1/25/25 for December 2024. The NHA reported they initiated a PIP (Plan in Place) on 12/20/24 due to there were 41 falls in December 2024, and one fall with fracture. She stated she did not do QA (Quality analysis) on it.</p> <p>Review of the Job Description for the Administrator, signed on 1/9/24 showed the Position Purpose was Leads, guides, and directs the operations of the health care facility in accordance with local, state, and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents. The Major Duties and Responsibilities included: Ensures resident incidents and concerns that rise to a reportable event such as alleged abuse neglect, mistreatment, misappropriation, etc. (etcetera) are reported to the correct entity within the stated regulatory requirement.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the job description of Director of Nursing, signed by the DON on 10/25/24. The description showed the DON was to participate in daily or weekly management team meetings to discuss census changes, resident changes in status, complaints, or concerns. The description included: Monitors for allegations of potential abuse or neglect, or misappropriation of resident property, and participates in the investigative process.</p> <p>Review of the policy - Abuse, Neglect, and Exploitation, reviewed 4/2024, revealed It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of the resident property. The policy defined Serious Bodily Injury as an injury involving extreme physical pain; Involving substantial risk of death; Involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical interventions such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse. Neglect was defined as failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy revealed the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: (a.) Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involved abuse or result in a serious bodily injury.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Cross Reference F921</p> <p>Based on observations, interviews, and record review, the facility failed to provide supervision and failed to prevent accident hazards to prevent a fall with injury for one resident (#6) of 19 ambulatory residents in the memory care unit. The facility failed to replace a clean-out drain located in a high traffic area of the facility's memory care unit and failed to promptly and effectively address flooring issues, resulting in an unsafe walkway, where Resident #6 tripped and fell .</p> <p>On 1/20/2025, Resident #6 was ambulating in the hallway outside her room and suffered a fall significantly impairing the ability to walk independently and complete Activities of Daily Living (ADLs) at her prior functional level. The resident suffered a significant change due to a fractured right femoral head requiring a surgical intervention of a right hip arthroplasty.</p> <p>The facility's failure to provide supervision and prevent accident hazards caused serious harm and injuries to Resident #6 and placed 18 additional ambulatory residents in the memory care unit at risk for serious injury, harm, and/or death. This failure resulted in the determination of Immediate Jeopardy on 1/20/25.</p> <p>The findings of Immediate Jeopardy were determined to be removed on 2/28/25 and the severity and scope was reduced to a D.</p> <p>Findings included:</p> <p>A review of Resident #6's admission record revealed the resident was [AGE] years old, originally admitted to the facility on [DATE], with a recent hospital stay from 1/20/25 to 1/26/25. The record showed diagnoses to include a displaced fracture of base of neck of right femur subsequent encounter for closed fracture with routine healing, aftercare following joint replacement surgery, difficulty in walking, presence of right artificial hip joint, and dementia and other diseases classified elsewhere unspecified severity with agitation.</p> <p>A review of the Situation, Background, Appearance, and Review (SBAR) Communication Form and Progress Note revealed Resident #6 had a change in condition of a fall on 1/20/25. The Situation section of the form documented status post fall, trip and fall in hallway, complaining of lower back and right leg pain. The Background section documented the resident has new pain with an intensity of 9 out of 10 (10 being the worst). The Appearance section documented status post fall in hallway, left in place due to pain on movement. 911 called. The Review and Notify section documented that the primary care clinician was notified on 1/20/2025 at 8:40 a.m. with recommendations to send to the emergency room (ER) for evaluation. The Family Member (FM) was notified on 1/20/2025 at 8:44 a.m.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of Resident #6's hospital History and Physical Report, dated 1/20/25 at 12:59 p.m. revealed this [AGE] year-old female had a medical history of dementia, dyslipidemia, and COPD [chronic obstructive pulmonary disease]. The nursing home resident, presented to the hospital from the nursing home after a fall. The patient was found on the ground and complaining of right hip pain. The patient's baseline was confused, and she could only recognize her [FM]. The completed radiology imaging studies, on 1/20/25 at 10:44 a.m. showed a right femoral neck fracture. The Computed Tomography Scan (CT) of the pelvis without contrast, on 1/20/25 at 10:04 a.m., revealed impacted right femoral neck fracture with angulation and mild displacement. The X-ray results of the right femur and right hip with pelvis showed normal mineralization.</p> <p>A review of a hospital consultation note dated 1/20/25 at 6:04 p.m. showed the resident was complaining of right hip pain and the physical examination showed the right lower extremity was shortened and externally rotated. The assessment/plan showed resident would benefit from operative intervention of the right hip in order to provide stability to the fracture and promote satisfactory healing, to improve pain, to facilitate early motion and mobilization and to prevent complications associated with prolonged bedrest. The risks, benefits, complications, and alternatives treatments were explained to the patient and FM. This included the possibilities of infection, deep vein thrombosis, reaction to anesthesia, neurovascular compromise, death or dying on the table, incomplete relief of symptoms, and chronic pain or stiffness.</p> <p>A review of the operative report on 1/21/25 at 9:08 a.m., showed Resident #6 had undergone a right hip hemiarthroplasty. The post-operative X-ray results showed the prosthesis was well-seated with no evidence of hardware loosening or failure.</p> <p>A review of Resident #6's clinical record at the facility prior to the 1/20/25 fall with a fracture revealed a quarterly Minimum Data Set (MDS), dated [DATE]. The cognitive pattern (Section C) showed a Brief Interview of Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. The functional abilities assessment (Section GG) revealed the resident was independent with eating, oral and toileting hygiene, and upper/lower body dressing. The resident required supervision with shower/bathing self, putting on/taking off footwear, and personal hygiene. The resident was independent with rolling left to right, sitting to lying, lying to sitting, sit to stand, transferring from chair/bed-to-chair, toilet transferring, walking 10 feet and walking 50 feet with two turns. The resident required partial assistance with tub/shower transfer, and supervision with walking 150 feet. The resident was always incontinent of bladder and frequently incontinent of bowel (Section H). The health conditions assessment (Section J) revealed the resident had no pain 5 days prior to the assessment, and had not fallen since admission/entry, reentry, or prior assessment.</p> <p>A review of Resident #6's last Physical Therapy (PT) Discharge Summary (prior to the 1/20/25 fall with a fracture) was dated 12/26/2024 and showed the resident was able to ambulate with no assistive device with modified independence (MI) for up to 300 ft. or as tolerated on level surface with verbal cues for directional changes.</p> <p>A review of Resident #6's last Fall Risk Evaluation (prior to the 1/20/25 fall with a fracture) was dated for a last known fall on 11/25/24 with a fall risk score of 9 (a score of 8 or higher indicates a fall risk).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of a facility note dated 1/26/25 at 5:30 p.m., showed Resident #6 returned to the facility from the hospital following a right hip hemiarthroplasty (related to the fall on 1/20/25). The record showed the resident was in pain whenever touched. The resident had a surgical wound on the right thigh.</p> <p>A review of a Fall Risk Evaluation conducted on 1/26/2025 at 5:39 p.m. showed the last known fall was on 1/20/25. The resident's fall risk score was 17.</p> <p>A review of a PT Evaluation dated 1/27/2025 showed Resident #6's prior level of function (PLOF) for bed mobility and transfers was independent with a baseline on 1/27/2025 of total assistance. The PLOF for walking was supervision with rolling walker up to 200 feet with a baseline on 1/27/25 of unable.</p> <p>A review of Resident #6's 5-day MDS (post fall and hospitalization), dated 1/28/25, revealed the resident had a BIMS score of 00, indicating severe impairment. The functional abilities assessment showed the resident was dependent on eating, oral and toileting hygiene, shower/bathing, upper/lower body dressing, and putting on/taking off footwear. The resident was dependent for rolling left to right, sitting to lying, lying to sitting, sit to stand, transferring from chair/bed-to-chair, toilet transferring, car transferring, walking 10 feet, walking 50 feet with two turns, and walking 150 feet. The assessment showed the resident was using a manual wheelchair. The resident was incontinent of bowel and bladder. The health conditions revealed frequent pain, no falls in the last month prior to admission/entry or reentry, no fracture related to a fall in the 6 months prior to admission/entry or reentry and had major surgery during the 100 days prior to admission.</p> <p>A review of Resident #6's care plan initiated on 8/21/2024 and revised on 1/30/2025 revealed the resident was at risk for falls related to history of falls, poor safety awareness, incontinence, dementia, psychotropic medication use, and neuropathy.</p> <p>The interventions for the care plan included:</p> <p>Ensure resident has a safe environment: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position; handrails on walls, personal items within reach) initiated on 8/21/2024.</p> <p>1/20/2025 Keep environment/walkway free of trip hazards initiated on 1/20/25 and revised on 1/30/2025.</p> <p>10/25/2024 Family to assist with decluttering room for safety initiated on 11/25/2024 and revised on 1/30/2025.</p> <p>2/12/2025 Scoop mattress initiated on 2/13/2025.</p> <p>During a facility tour on 2/24/25 at 10:30 a.m. an area of rough and uneven concrete approximately 3ft (feet) x 2 ft in the middle of the corridor of the 200-hall located inside the memory care unit. The uneven concrete area had a drain cap located near the middle that was raised. The concrete area was a known high-traffic area, outside of the secured memory care dining room, the nurses' station, and just outside of Resident #6's room.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of an electronic work order created on 12/18/24 at 6:31 p.m. by Staff G, Licensed Practical Nurse (LPN) revealed clean out cover missing, location 200 hallway, priority level medium, and a note/comment to repair drain on 200 hallway asap [as soon as possible]. The status of the order was updated by the Director of Maintenance (DOM) on 12/27/24 at 2:49 p.m. as Set to Completed. A Room Audit Form, for Project Clean OUT 200 Hall with a start date of 12/18/24 revealed daily notes monitoring the clean out cover area from 12/18/24 to 1/24/25 documented by the DOM. The first entry on the log, dated 12/18/2024, showed the (DOM) placed a metal sheet cover over the drain opening with tape. The entry on 12/27/24, the day the work order status was updated, showed a visual inspection was done in the morning and fresh tape was applied that evening. None of the entries between 12/18/24 and 12/27/24 showed any additional work outside of visual inspection and applications of fresh tape was completed. A review of the audit log revealed no documentation to show the area was visually inspected to ensure safety of residents, staff, and visitors on 12/21/24, 12/22/24, 12/25/24, 12/28/24, 12/29/24, 12/31/24, 1/4/25, 1/5/25, 1/10/25, 1/11/25, 1/12/25, 1/15/25, 1/16/25, 1/22/25, and 1/23/25. The log showed on 1/20/25 morning - Resident [#6] fall, fresh tape -plumber called -Received Quote & Sent. The log showed on 1/24/25 evening - Job completed. A review of an email dated 2/25/25 confirmed the plumbing company had completed a repair of the area on the 200 hall on 1/24/25, 4 days after Resident #6 fell and 37 days after the original work order was created.</p> <p>An interview on 2/25/25 at 1:34 p.m. with Staff C, Certified Nursing Assistant (CNA) revealed she witnessed Resident #6's incident on 1/20/25. Staff C, CNA reported Resident #6 was in the hallway with her FM. The resident was attempting to detach herself from tape on the floor in the unrepaired plumbing area that was covered with concrete. The staff member stated the tape was not holding anything down. Staff C saw Resident #6 lose her balance and fall.</p> <p>Review of a written statement by Staff C, CNA dated 1/20/25 at 8:30 a.m. showed Staff C was coming down the hall with a breakfast tray and witnessed Resident #6 trip and fall over an area on the floor. The tape was coming up and Resident #6's foot got caught on it.</p> <p>On 2/25/25 at 9:45 a.m., an interview was conducted with the DOM. He stated on 200-hall, the memory care unit, a resident had pulled the clean-out cap off, on 12/18/24. The DOM reported roping the area off and cutting a metal piece to fit on top of the missing cap. He stated this was done after Resident #6 had fallen. The DOM stated the facility had plumbers come in on 1/24/25. The DOM stated from 12/18/24 to 1/24/25, he had put several patches on the area, and went back every day to make sure it was secure and safe. The DOM reported the plumbers removed the tile all the way around the clean out cap, leaving a cemented patch.</p> <p>On 2/25/25 at 10:46 a.m., the DOM observed the 200 hall and showed the area where Resident #6 had fallen in the hallway. The area was near the nursing station in the 200-hall and just outside of Resident 6's room at that time of the 1/20/25 incident. The DOM observed an additional area of missing floor tiles on the 200 hall and stated the facility had just received the diamond blades to smooth out the concrete. He stated the plumbers had to remove the tiles to fix a plumbing issue. During the time of this interview, the DOM confirmed the area where Resident #6 had fallen was still uneven due to the concrete patch left by the plumbers on 1/24/25.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A follow-up interview on 2/26/25 beginning at 3:05 p.m. with the DOM revealed the rough concrete patch observed during the survey beginning on 2/24/25 was part of the repair. The DOM stated he had to research a replacement cap since the missing cover was so old. The DOM stated the plumber did not have a cap to fit the cast iron piping, so the plumber had to make the hole bigger and cut pipe to fix it. The DOM revealed this repair happened in the middle of January. The DOM stated he had put a metal plate on the area trying to save the company money in December 2024. The DOM reported he was researching it to try to fix it himself before calling the plumbers in, but after Resident #6's fall, he was done searching for the replacement and decided to get plumbers in. The DOM stated he felt the location where Resident #6 fell was safe and felt the [brand name] tape was a good tape to use as a temporary fix. The DOM reported the diamond grinding wheel, needed to smooth out concrete, had been back ordered and came in last week. The DOM said he had looked at local merchants for the grinding wheel, but they did not have the size needed in stock. The DOM stated the diamond wheel was delivered on 2/14/25, the day before he went on vacation. Review of the online merchant's receipt for the 4.5-inch diamond concrete grinding wheel showed the order was placed on 1/27/25 and shipped on 1/27/25. At the time of this interview, the area where Resident #6 fell was still not fully repaired leaving a rough and uneven flooring surface in this high traffic area.</p> <p>During an interview on 2/25/25 at 2:15 p.m., the Director of Nursing (DON) stated Resident #6 had been ambulating in the hallway with a family member and her foot kind of got stuck on tape. The DON reported the FM grabbed the resident had pulled her, then the resident lost her balance and fell. The DON stated the resident had a history of osteopenia and because of right hip pain the resident was left on floor. The DON stated she interviewed Staff B/CNA, Staff C/CNA, and Staff E, Licensed Practical Nurse (LPN). The DON stated Staff E, LPN was sitting at the desk and did not witness the fall, but heard the resident call out and saw her lying on the right side. The DON confirmed Resident #6 suffered a fall, was transferred out to the hospital, had surgery and came back to the facility. The DON stated Resident #6 had suffered a previous fall on 10/25/24. She stated the resident had a big chair in her room at the time so the family decluttered the room and when the resident started ambulating, the facility ensured the environment was free of clutter and slip hazards to prevent additional falls.</p> <p>An interview was conducted on 2/26/25 at 12:00 p.m. with Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member described the area of concrete as similar to other drains on unit, showing a circular drain with a square metal outer plate. Staff J, LPN/UM stated the residents on the unit like to pick at it and had pulled the square metal plate up. Staff J, LPN/UM stated maintenance had covered the area with a metal square that was approximately the same size as the missing plate and secured it to the floor with yellow and black striped industrial tape so it would be recognized as a caution area. Staff J, LPN/UM stated she doubted the residents in the memory care unit would have recognized the tape as a caution area. The staff member stated the concrete area was a high-traffic area as it was between the dining room, Resident #6's room, and the nursing station on the memory care unit. Staff J, LPN/UM stated they had a lot of residents wandering up and down the hallways due to dementia on the unit. Staff J, LPN/UM said she could only report it to maintenance, and then it was out of her hands. Staff J, LPN/UM stated the metal and tape was a hazard, and during the repair period, the area had become larger in size.</p> <p>A review of a work order dated 12/3/24 at 2:24 p.m. showed Staff J, LPN/UM reported missing tile on the floor of the 200 hallway with a medium priority level. The work order was acknowledged by the DOM on 12/27/24 at 3:30 p.m. with a status of Set to-In-Progress. The work order was updated on 2/26/25 at 2:17 p.m. by the DOM with a status of Set to completed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 2/24/25 at 10:18 a.m., a second area in hall 200 towards the front of the facility, near the janitor supply closet #3 was observed with 12 missing tiles. The area was in the walking path of residents in the memory care unit. The area had a raised drain with a cap near the middle of it. An immediate interview was conducted with Staff B, Certified Nursing Assistant (CNA) who confirmed the area had been in disrepair for a long time and estimated it to be approximately 6 to 8 months.</p> <p>On 2/24/25 at 10:38 a.m., the entrance ramp to the 400-hall was observed missing five full carpet squares (approximately 2 ft x 2 ft) and 5 half carpet squares leaving exposed concrete with a raised drain that was not level to the concrete, and the carpet that remained was not level with the concrete. A yellow traffic cone was placed in the corner from the hallway to the ramp. This area was the inside entrance for residents, staff and visitors to access the 400-hall and used frequently by residents with ambulation devices and wheelchairs.</p> <p>On 2/27/25 at 2:04 p.m., the Regional DOM reported not being aware of the flooring issue. The Regional DOM stated depending on severity, if something could not be handled in-house the facility contacted vendors for repairs. The Regional DOM expected something to be implemented promptly, within one to two weeks for the safety of the residents.</p> <p>During a facility tour of the 200 hall on 02/27/2025 at 2:21 p.m. with the Nursing Home Administrator (NHA), revealed tiles that were popping up on the edges where the facility had replaced flooring using old tiles. The NHA confirmed the area was a hazard for someone with a shuffling gait. The NHA stated the tiles needed to be put down again and better. The NHA stated her expectation was an immediate fix for any hazard affecting residents. The NHA observed the area where Resident #6 fell and stated she expected the area to be safe for the residents. The NHA stated it was unacceptable to wait to repair the floors.</p> <p>Photographic evidence was obtained.</p> <p>Review of the Fall Prevention Program, implemented on 9/1/24, revealed Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy defined a fall as an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere.</p> <p>The policy explanation and compliance guidelines showed the facility utilized a standardized risk assessment for determining a resident's fall risk. Low/moderate risk protocols include implementation of universal environmental interventions that decrease the risk of a resident falling, including, but not limited to: A clear pathway to the bathroom and bedroom doors.</p> <p>A review of the facility's immediate actions to remove the Immediate Jeopardy included:</p> <p>1. Immediate Action:</p> <p>Environmental rounds completed, identified areas of concern noted.</p> <p>Summoned Corporate Plant Operations support team for assistance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Quality review completed for all current residents sustaining a fall to ensure plan of care is in place in the past 6 months, no discrepancies noted.</p> <p>Medical Record Review of all residents with falls with major injury in the past 6 months conducted; no discrepancies noted.</p> <p>99.5% of all facility staff were educated by 9:00 a.m. on 2/28/2025.</p> <p>Initiated and assigned direct care staff member as Hallway Safety Monitor on secure unit (200 Hall) for additional supervision. Hallway Safety Monitor will be assigned for 24 hours a day X 7 days to establish a pattern of ambulatory residents. When pattern is established, Hallway Safety Monitor will be staffed from 0700 to 2300 daily X 14 days. Then, as pattern is further established, Hallway Safety Monitor will be staffed 12 hours daily X 30 days. Hallway Safety Monitor staffing hours will be adjusted as indicated.</p> <p>2. Identification of others at risk was accomplished by:</p> <p>On 2/26/25-2/27/25 The Director of Clinical Services (DCS) and designee(s) reassessed all residents residing in the facility for fall risk via Fall Risk Evaluation.</p> <p>Facility implemented Activities Invitation Rounds for residents identified at risk for falls. Activities staff will encourage identified residents to attend activities of choice and document on log to establish a pattern of attendance/ preferences.</p> <p>The Care Plan Coordinator(s) completed review of care plans to ensure all residents identified as at risk for falls (Fall Risk Score of 8 or higher) had safety measures, as well as resident specific interventions in place and to ensure the safety measures and resident specific interventions are also reflected on the Kardex so that the CNA's have access to this information.</p> <p>Quality review completed for monitoring of environmental hazards with a focus on uneven surfaces and fall hazards.</p> <p>Identified environmental concerns addressed by priority level, initiated repairs and ongoing.</p> <p>Record review of Resident #6 completed. Therapy screen completed on 1/22/2025; PT/OT services ongoing. Resident seen by psych provider. No changes in mood or mentation noted. Pain Management in place. Resident has orders for pharmacological pain intervention: Tylenol, Lidocaine External Patch, and Tramadol as of 2/27/25. Resident was previously on Norco, but medication was discontinued.</p> <p>3.Actions to Prevent Occurrence/Recurrence:</p> <p>NHA, DCS, and Plant Operations/Maintenance Director re-educated on ensuring resident environment is free of hazards with emphasis on timely completion.</p> <p>Regional DCS educated the DCS on the facility's Fall Prevention Program, all facility fall related policies, how to conduct an RCA, and how to ensure incident investigations are timely and complete.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>DCS/designee re-educated staff on facility Fall Prevention Program guidelines, following care plan/Kardex interventions, as well as all facility fall related policies.</p> <p>DCS/Designee re-educated staff on Abuse, Neglect, Exploitation Policy.</p> <p>DCS/Designee re-educated staff on Residents' Rights.</p> <p>DCS/Designee re-educated staff on Accidents and Supervision Policy.</p> <p>DCS/Designee re-educated staff on Recognizing & Reporting Hazards.</p> <p>DCS/Designee re-educated staff on Redirecting Residents with Cognitive Deficits from Environmental Hazards</p> <p>DCS/Designee re-educated staff on securing hazardous areas until plant ops clears, ensuring no harm.</p> <p>The Director of Clinical Services/designee to conduct quality monitoring of new admission fall risk evaluation completion to ensure that risk factors, safety measures, and resident specific interventions are reflected on the care plan and Kardex five times weekly x 8 weeks, three times weekly x 2 weeks; twice weekly x 2 weeks, then weekly and PRN (as needed) as indicated.</p> <p>A Performance Improvement Plan (PIP) has been initiated to report on the above monitoring and auditing procedures. All finding from the PIP will be presented at the monthly Quality Assessment & Assurance (QAA) meeting. Monitoring/auditing and reporting will continue for a minimum of three months.</p> <p>4. NHA/Plant Ops/Designee will round to ensure facility is free of hazards daily X 7 days, then daily X 5 days, then twice weekly x 8 weeks; then weekly and PRN as indicated. DON/designee will review all falls at the clinical meeting with the IDT (interdisciplinary) daily X 5 (Business Days) for 4 weeks to ensure appropriate fall interventions are implemented, the resident's care plan has been reviewed and revised, and the Kardex has been update; then 3 x weekly X 4, then twice weekly x 4, then weekly x 4, then monthly x 3; and PRN as indicated. Regional DCS will review falls weekly for three months to ensure a RCA (root cause analysis) has been conducted and that resident specific interventions are reflected in the care plan as well as updated on the Kardex. These audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the assigned auditors for three months.</p> <p>Verification of the facility's removal plan was conducted by the survey team on 2/28/25.</p> <p>On 2/28/25 observations were made to ensure the facility repaired the concrete area in the 200-hall to include level tiles and repaired the area at the end of the 200-hall to ensure the tiled area was level. The facility removed the carpet on the 400-ramp and replaced it with two pieces of rolled carpet. The facility educated 99% of their staff on notifying supervisors of accident hazards and to notify other management if the hazard was not repaired.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Lakeland Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Lakeland Hills Blvd Lakeland, FL 33805	
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interviews were conducted with 77 staff members, which included the NHA, the DOM, 13 licensed nurses, 17 CNAs, and 45 other staff members across all shifts. The staff members were able to state that they had been trained and were knowledgeable about the new procedures. Interview with the NHA on 2/28/25 revealed a couple of the staff were not reachable, but a system was put into place for education prior to their next working day.</p> <p>Based on verification of the facility's Immediate Jeopardy removal plan the immediate jeopardy was determined to be removed on 2/28/25 and the non-compliance was reduced to a scope and severity of D.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on interview and record review the facility failed to ensure documentation was accurate and complete for one (#4) of one resident related to the documentation of a change in condition resulting in cardio-pulmonary resuscitation (CPR) being administered.</p> <p>Findings included:</p> <p>Review of Resident #4's Admission Record revealed the resident was most recently admitted to the facility on [DATE]. The record included diagnoses of idiopathic hypotension, acute respiratory failure with hypoxia, unspecified pulmonary hypertension, paroxysmal atrial fibrillation, unspecified heart failure, and dependence on supplemental oxygen.</p> <p>Review of Resident #4's clinical record showed a Hospital Transfer Form, dated [DATE] at 1:40 p.m. showed the resident was a Full Code.</p> <p>Review of a Situation, Background, Appearance, and Review/Notify (SBAR) assessment dated [DATE] at 9:37 a.m. showed notification to the provider of resident change in condition related to food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts).</p> <p>Review of Resident #4's progress note, dated [DATE] at 1:56 p.m. showed the resident was transferred from one room to another at 1:30 p.m., and the resident was found unresponsive. Emergency Medical Transport (EMT) was called, and the physician and family were notified.</p> <p>An interview was conducted on [DATE] at 3:22 p.m. with the Director of Nursing (DON). The DON reported Resident #4 was transferred on [DATE], and stated the resident had CPR initiated in the facility, and the physician present in the facility assisted. She stated the expectation was for staff to document CPR was initiated and EMT was called in the clinical record. A follow-up interview with the DON on [DATE] at 3:58 p. m. confirmed the clinical record and transfer form did not reveal the resident had received CPR.</p> <p>Review of the policy - Documentation in Medical Record, implemented ,d+[DATE], showed Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. The compliance guidelines included:</p> <ol style="list-style-type: none"> 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3c. Documentation shall be timely and in chronological order. 		

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<p>F 0921</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Cross Reference F689</p> <p>Based on observations, interviews and record reviews, the facility failed to provide a safe environment, free from flooring hazards for staff, the public, and 19 ambulatory residents in the facility's secure memory care unit. One (Resident #6) of the 19 ambulatory residents fell on [DATE], sustained a fracture to the right femoral head (top of thigh bone), required a transfer to a higher level of care, and surgical intervention due to a floor repair that was not completed by the facility. The injuries to Resident #6 caused a significant decline in her ability to ambulate and complete activities of daily living (ADLs) at her prior functional level.</p> <p>The facility's failure to maintain a safe walking environment caused serious injury and harm to Resident #6 and placed 18 additional ambulatory memory care residents, staff, and visitors at risk for serious injury, harm, and/or death. This failure resulted in the determination of Immediate Jeopardy on 1/20/25.</p> <p>The findings of Immediate Jeopardy were determined to be removed on 2/28/25 and the severity and scope was reduced to a D.</p> <p>Findings included:</p> <p>A review of an electronic work order created on 12/18/24 at 6:31 p.m. by Staff G, Licensed Practical Nurse (LPN) revealed clean out cover missing, location 200 hallway, priority level medium, and a note/comment to repair drain on 200 hallway asap [as soon as possible]. The status of the order was updated by the Director of Maintenance (DOM) on 12/27/24 at 2:49 p.m. as Set to Completed. A Room Audit Form, for Project Clean OUT 200 Hall with a start date of 12/18/24 revealed daily notes monitoring the clean out cover area from 12/18/24 to 1/24/25 documented by the DOM. The first entry on the log, dated 12/18/2024, showed the (DOM) placed a metal sheet cover over the drain opening with tape. The entry on 12/27/24, the day the work order status was updated, showed a visual inspection was done in the morning and fresh tape was applied that evening. None of the entries between 12/18/24 and 12/27/24 showed any additional work outside of visual inspection and applications of fresh tape was completed. A review of the audit log revealed no documentation to show the area was visually inspected to ensure safety of residents, staff, and visitors on 12/21/24, 12/22/24, 12/25/24, 12/28/24, 12/29/24, 12/31/24, 1/4/25, 1/5/25, 1/10/25, 1/11/25, 1/12/25, 1/15/25, 1/16/25, 1/22/25, and 1/23/25. The log showed on 1/20/25 morning - Resident [#6] fall, fresh tape -plumber called -Received Quote & Sent. The log showed on 1/24/25 evening - Job completed. A review of an email dated 2/25/25 confirmed the plumbing company had completed a repair of the area on the 200 hall on 1/24/25, 4 days after Resident #6 fell and 37 days after the original work order was created.</p> <p>During a facility tour on 2/24/25 at 10:30 a.m. an area of rough and uneven concrete approximately 3ft (feet) x 2 ft in the middle of the corridor of the 200-hall located inside the memory care unit. The uneven concrete area had a drain cap located near the middle that was raised. The concrete area was a known high-traffic area, outside of the secured memory care dining room, the nurses' station, and just outside of Resident #6's room.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of Resident #6's admission record revealed the resident was [AGE] years old, originally admitted to the facility on [DATE], with a recent hospital stay from 1/20/25 to 1/26/25. The record showed diagnoses to include a displaced fracture of base of neck of right femur subsequent encounter for closed fracture with routine healing, aftercare following joint replacement surgery, difficulty in walking, presence of right artificial hip joint, and dementia and other diseases classified elsewhere unspecified severity with agitation.</p> <p>A review of the Situation, Background, Appearance, and Review (SBAR) evaluation for Resident #6, dated 1/20/25, showed the resident tripped and fell in the hallway, complaining of lower back and right leg pain. The evaluation revealed new pain in the right thigh, lower back and right leg with an intensity score of 9 of 10. The documentation revealed the resident was left in place due to pain on movement, and the primary physician placed an order to send the resident to the emergency room (ER) for evaluation on 1/20/25 at 8:40 a.m.</p> <p>An interview on 2/25/25 at 1:34 p.m. with Staff C, Certified Nursing Assistant (CNA) revealed she witnessed Resident #6's incident on 1/20/25. Staff C, CNA reported Resident #6 was in the hallway with her Family Member (FM). The resident was attempting to detach herself from tape on the floor in the unrepaired plumbing area that was covered with concrete. The staff member stated the tape was not holding anything down. Staff C saw Resident #6 lose her balance and fall.</p> <p>Review of a written statement by Staff C, CNA dated 1/20/25 at 8:30 a.m. showed Staff C was coming down the hall with a breakfast tray and witnessed Resident #6 trip and fall over an area on the floor. The tape was coming up and Resident #6's foot got caught on it.</p> <p>A review of Resident #6's hospital History and Physical Report, dated 1/20/25 at 12:59 p.m. revealed This is a [AGE] year-old female with medical history of dementia, dyslipidemia, COPD [chronic obstructive pulmonary disease], nursing home resident, presented to hospital for [sic] facility after a fall. Patient was found on the ground and complaining of right hip pain, patient's baseline is confused, only be able to recognize her [FM], but nobody else, be able to eat by herself. When I saw the patient, her [FM] at bedside, provided all the history. The completed radiology imaging studies, on 1/20/25 at 10:44 a.m. showed a right femoral neck fracture. The Computed Tomography Scan (CT) of the pelvis without contrast, on 1/20/25 at 10:04 a.m., revealed impacted right femoral neck fracture with angulation and mild displacement. The X-ray results of the right femur and right hip with pelvis showed normal mineralization.</p> <p>A review of a hospital consultation note dated 1/20/25 at 6:04 p.m. showed the resident was complaining of right hip pain and the physical examination showed the right lower extremity was shortened and externally rotated. The assessment/plan showed resident would benefit from operative intervention of the right hip in order to provide stability to the fracture and promote satisfactory healing, to improve pain, to facilitate early motion and mobilization and to prevent complications associated with prolonged bedrest. The risks, benefits, complications, and alternatives treatments were explained to the patient and FM. This included the possibilities of infection, deep vein thrombosis, reaction to anesthesia, neurovascular compromise, death or dying on the table, incomplete relief of symptoms, and chronic pain or stiffness.</p> <p>A review of the operative report on 1/21/25 at 9:08 a.m., showed Resident #6 had undergone a right hip hemiarthroplasty. The post-operative X-ray results showed the prosthesis was well-seated with no evidence of hardware loosening or failure.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the hospital Physical Therapy (PT) evaluation dated 1/22/25 at 9:38 a.m., revealed the FM had reported a prior functioning of being able to mobilize with a walker. The PT assessment showed Impairments/Limitations: Ambulation deficits, Bed mobility deficits, Cognitive deficits, Range of motion deficits, Safety awareness deficits, Transfer deficits, Transition deficits</p> <p>Barriers to Safe Discharge: Insight into deficits, Needs Assist for Mobility, Needs Assist for Transfer, Safety awareness</p> <p>Summary of Findings: Pt. [patient] very confused, unable to follow commands, dep[endent] for all mobility.</p> <p>A review of a facility note dated 1/26/25 at 5:30 p.m., showed Resident #6 returned to the facility from the hospital following a right hip hemiarthroplasty. The record showed the resident was in pain whenever touched. The resident had a surgical wound on right thigh and staff recommended rehab unit for the resident.</p> <p>During an interview on 2/25/25 at 2:15 p.m., the Director of Nursing (DON) stated Resident #6 had been ambulating in the hallway with a family member and her foot kind of got stuck on tape. The DON reported the FM grabbed the resident had pulled her, then the resident lost her balance and fell . The DON stated the resident had a history of osteopenia and because of right hip pain the resident was left on floor. The DON stated she interviewed Staff B/CNA, Staff C/CNA, and Staff E, Licensed Practical Nurse (LPN). The DON stated Staff E, LPN was sitting at the desk and did not witness the fall, but heard the resident call out and saw her lying on the right side. The DON confirmed Resident #6 suffered a fall, was transferred out to the hospital, had surgery and came back to the facility. The DON stated Resident #6 had suffered a previous fall on 10/25/24. She stated the resident had a big chair in her room at the time so the family decluttered the room and when the resident started ambulating, the facility ensured the environment was free of clutter and slip hazards to prevent additional falls.</p> <p>On 2/25/25 at 9:45 a.m., an interview was conducted with the DOM. He stated on 200-hall, the memory care unit, a resident had pulled the clean-out cap off, on 12/18/24. The DOM reported roping the area off and cutting a metal piece to fit on top of the missing cap. He stated this was done after Resident #6 had fallen. The DOM stated the facility had plumbers come in on 1/24/25. The DOM stated from 12/18/24 to 1/24/25, he had put several patches on the area, and went back every day to make sure it was secure and safe. The DOM reported the plumbers removed the tile all the way around the clean out cap, leaving a cemented patch.</p> <p>On 2/25/25 at 10:46 a.m., the DOM observed the 200 hall and showed the area where Resident #6 had fallen in the hallway. The area was near the nursing station in the 200-hall and just outside of Resident 6's room at that time of the 1/20/25 incident. The DOM observed an additional area of missing floor tiles on the 200 hall and stated the facility had just received the diamond blades to smooth out the concrete. He stated the plumbers had to remove the tiles to fix a plumbing issue. During the time of this interview, the DOM confirmed the area where Resident #6 had fallen was still uneven due to the concrete patch left by the plumbers on 1/24/25.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 2/26/25 at 12:00 p.m. with Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member described the area of concrete as similar to other drains on unit, showing a circular drain with a square metal outer plate. Staff J, LPN/UM stated the residents on the unit like to pick at it and had pulled the square metal plate up. Staff J, LPN/UM stated maintenance had covered the area with a metal square that was approximately the same size as the missing plate and secured it to the floor with yellow and black striped industrial tape so it would be recognized as a caution area. Staff J, LPN/UM stated she doubted the residents in the memory care unit would have recognized the tape as a caution area. The staff member stated the concrete area was a high-traffic area as it was between the dining room, Resident #6's room, and the nursing station on the memory care unit. Staff J, LPN/UM stated they had a lot of residents wandering up and down the hallways due to dementia on the unit. Staff J, LPN/UM said she could only report it to maintenance, and then it was out of her hands. Staff J, LPN/UM stated the metal and tape was a hazard, and during the repair period, the area had become larger in size.</p> <p>A follow-up interview on 2/26/25 beginning at 3:05 p.m. with the DOM revealed the rough concrete patch observed during the survey beginning on 2/24/25 was part of the repair. The DOM stated he had to research a replacement cap since the missing cover was so old. The DOM stated the plumber did not have a cap to fit the cast iron piping, so the plumber had to make the hole bigger and cut pipe to fix it. The DOM revealed this repair happened in the middle of January. The DOM stated he had put a metal plate on the area trying to save the company money in December 2024. The DOM reported he was researching it to try to fix it himself before calling the plumbers in, but after Resident #6's fall, he was done searching for the replacement and decided to get plumbers in. The DOM stated he felt the location where Resident #6 fell was safe and felt the [brand name] tape was a good tape to use as a temporary fix. The DOM reported the diamond grinding wheel, needed to smooth out concrete, had been back ordered and came in last week. The DOM said he had looked at local merchants for the grinding wheel, but they did not have the size needed in stock. The DOM stated the diamond wheel was delivered on 2/14/25, the day before he went on vacation. Review of the online merchant's receipt for the 4.5-inch diamond concrete grinding wheel showed the order was placed on 1/27/25 and shipped on 1/27/25. At the time of this interview, the area where Resident #6 fell was still not fully repaired leaving a rough and uneven flooring surface in this high traffic area.</p> <p>On 2/27/25 at 2:04 p.m., the Regional DOM reported not being aware of the flooring issue. The Regional DOM stated depending on severity, if something could not be handled in-house the facility contacted vendors for repairs. The Regional DOM expected something to be implemented promptly, within one to two weeks for the safety of the residents.</p> <p>On 2/24/25 at 10:18 a.m., a second area in hall 200 towards the front of the facility, near the janitor supply closet #3 was observed with 12 missing tiles. The area was in the walking path of residents in the memory care unit. The area had a raised drain with a cap near the middle of it. An immediate interview was conducted with Staff B, Certified Nursing Assistant (CNA) who confirmed the area had been in disrepair for a long time and estimated it to be approximately 6 to 8 months.</p> <p>A review of a work order dated 12/3/24 at 2:24 p.m. showed Staff J, LPN/UM reported missing tile on the floor of the 200 hallway with a medium priority level. The work order was acknowledged by the DOM on 12/27/24 at 3:30 p.m. with a status of Set to-In-Progress. The work order was updated on 2/26/25 at 2:17 p.m. by the DOM with a status of Set to completed.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 2/24/25 at 10:38 a.m., the entrance ramp to the 400-hall was observed missing five full carpet squares (approximately 2 ft x 2 ft) and 5 half carpet squares leaving exposed concrete with a raised drain that was not level to the concrete, and the carpet that remained was not level with the concrete. A yellow traffic cone was placed in the corner from the hallway to the ramp. This area was the inside entrance for residents, staff and visitors to access the 400-hall and used frequently by residents with ambulation devices and wheelchairs.</p> <p>During a facility tour of the 200 hall on 02/27/2025 at 2:21 p.m. with the Nursing Home Administrator (NHA), revealed tiles that were popping up on the edges where the facility had replaced flooring using old tiles. The NHA confirmed the area was a hazard for someone with a shuffling gait. The NHA stated the tiles needed to be put down again and better. The NHA stated her expectation was an immediate fix for any hazard affecting residents. The NHA observed the area where Resident #6 fell and stated she expected the area to be safe for the residents. The NHA stated it was unacceptable to wait to repair the floors.</p> <p>Photographic evidence was obtained.</p> <p>A review of the Maintenance Director's job description signed on 10/24/24 by the DOM revealed:</p> <p>Position Purpose: Directs the day-to-day activities of the maintenance department in accordance with current federal, state, and local standards, guidelines and regulations governing the facility, and to ensure the facility is maintained in a safe and comfortable manner.</p> <p>The major duties and responsibilities included:</p> <p>Plans, develops, organizes, implements, evaluates, and directs the Maintenance Department, its programs and activities.</p> <p>Ensures the facility remains in compliance with all federal, state, and local regulations for life safety code compliance.</p> <p>Reviews the department's policies, procedure manuals, job descriptions, etc., at least annually for revisions and makes recommendations to the Assistant Administrator/Administrator.</p> <p>Prepares operating and staffing budgets for maintenance and monitors monthly.</p> <p>Ensures maintenance staff are properly trained on safety policies and procedures as well as monitors compliance.</p> <p>Ensures proper planning, direction, participation, and supervision of both preventative and unplanned maintenance and repair activities in the facility, which includes painting, plumbing, carpentry, HVAC, and electrical work.</p> <p>Purchases within budgetary responsibilities [sic] the general maintenance tools, supplies and equipment, safety equipment, and trains others in their appropriate use.</p> <p>Ensures that services performed by outside vendors are properly completed/supervised in accordance with contracts/work orders .</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensures facility's compliance with multiple OSHA standards .</p> <p>Develops and implements preventative maintenance tasks, document instructions and procedures for the preventative maintenance of facility and utility components and office equipment, as well as, mechanical, air conditioning, heating, and electrical systems, etc.</p> <p>Schedules department work hours (including vacation and holiday schedules), personnel, work assignments, etc., to expedite work .</p> <p>Ensures the facility's compliance with the law and other regulatory terms such as safety and building codes .</p> <p>Runs, operates, and assesses technical aspects of facility machinery, equipment, and buildings.</p> <p>A review of the Job Description for the Administrator signed on 1/9/24 revealed:</p> <p>Position Purpose: Leads, guides, and directs the operations of the health care facility in accordance with local, state, and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents.</p> <p>The major duties and responsibilities included:</p> <p>Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations.</p> <p>Plans, develops, organizes, implements, evaluates, and directs the facility's programs and activities in accordance with guidelines issued by the governing body.</p> <p>Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. Establishes an ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility .</p> <p>Leads and coordinates daily, weekly, bi-monthly or monthly management team meetings to discuss priorities and develop solutions with facility leaders such as census, collections, clinical health, survey readiness, customer service satisfaction, activity participation, etc .</p> <p>Evaluates work performance of department heads and maintains accountability across all departments in concert with Human Resources for expected performance outcomes in each respective department .</p> <p>Knows and understands .Code of Federal Regulations, Appendix PP State Operations Manual .Life Safety Code regulations .and all other regulatory entities that may apply .</p> <p>Performs rounds to observe residents and ensure overall needs are being met. Knows residents by name and sight. Practices management by walking around. Makes himself/herself available to employees at all levels by practicing an open-door policy.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Lakeland Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 Lakeland Hills Blvd 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.			
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<p>F 0921</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the policy titled, Safe and Homelike Environment, implemented 9/1/23, revealed: In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and home like environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>Definitions included: Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas; Orderly is defined as an uncluttered physical environment that is neat and well-kept.</p> <p>Policy explanation and compliance guidelines: Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.</p> <p>General Considerations: Report any unresolved environmental concerns to the Administrator.</p> <p>A review of the facility's immediate actions to remove the Immediate Jeopardy included:</p> <p>1. Immediate Action:</p> <p>NHA and Plant Operations Director performed environmental rounds on 2/26/2025, identified areas of concern noted and reported in the electronic maintenance records system. Work orders started in order of priority for hazards causing uneven surfaces, fall risk hazards, and items with potential to risk resident safety.</p> <p>Summoned Corporate Plant Operations support team for assistance on 2/26/2025</p> <p>Initiated repairs of identified areas of concern on 2/26/2025</p> <p>Tiles in high traffic area of secure unit (200 Hall, outside room [ROOM NUMBER]) repaired on 2/26/2025, part of repaired tiles began to shift, tiles replaced again on 2/27/2025.</p> <p>Tiles in high traffic area of secure unit (200 Hall, outside room [ROOM NUMBER]) repaired on 2/26/2025</p> <p>400 Hall ramp missing carpet tiles replaced on 2/26/2025, carpet tile surface continues to be uneven, all carpet tiles were removed from ramp and replaced with one solid carpet piece.</p> <p>On 2/27/2025 surveyors and NHA completed environmental rounds of the facility noting areas of continued concern.</p> <p>List compiled of concerns from environmental tour, all items entered in the electronic maintenance records system.</p> <p>300 Hall clean out with uneven surface repaired.</p> <p>99.5% of all facility staff were educated by 9:00 a.m. on 2/28/2025.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Initiated and assigned direct care staff member as Hallway Safety Monitor on secure unit (200 Hall) for additional supervision. Hallway Safety Monitor will be assigned 24 hours a day X 7 days to establish a pattern of ambulatory residents. When pattern is established, Hallway Safety Monitor will be staffed from 0700 to 2300 daily X 14 days. Then, as pattern is further established, Hallway Safety Monitor will be staffed 12 hours daily X 30 days. Hallway Safety Monitor staffing hours will be adjusted as indicated.</p> <p>2. Identification of others at risk was accomplished by:</p> <p>Quality review completed for monitoring of environmental hazards with a focus on uneven surfaces and fall hazards.</p> <p>NHA/Designee rounded facility to survey for environmental hazards.</p> <p>Identified environmental concerns reported via electronic maintenance records system, addressed by priority level, and repairs initiated and will be ongoing</p> <p>3. Actions to Prevent Occurrence/Recurrence:</p> <p>NHA, DCS (Director of Clinical Services), and Plant Operations/Maintenance Director re-educated on ensuring resident environment is free of hazards with emphasis on timely completion.</p> <p>DCS/Designee re-educated staff on Accidents and Supervision Policy.</p> <p>DCS/Designee re-educated staff on Recognizing & Reporting Hazards.</p> <p>DCS/Designee re-educated staff on Redirecting Residents with Cognitive Deficits from Environmental Hazards.</p> <p>DCS/Designee re-educated staff on securing hazardous areas until plant ops clears, ensuring no harm.</p> <p>Initiation and Assignment of direct care staff member as Hallway Safety Monitor for secure unit (200 Hall) for additional supervision and hazard identification.</p> <p>A Performance Improvement Plan (PIP) has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly Quality Assessment & Assurance (QAA) meeting. Monitoring/auditing and reporting will continue for a minimum of three months or until substantial compliance is determined.</p> <p>4. NHA/Plant Ops/Designee will round to ensure facility is free of hazards daily X 7 days, then daily X 5 days, then twice weekly x 8 weeks; then weekly and PRN (as needed) as indicated. These audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the assigned auditors for three months.</p> <p>Verification of the facility's removal plan was conducted by the survey team on 2/28/25.</p> <p>(continued on next page)</p>		

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