STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105428	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Mariam Health and Rehabilitation Center	1801 N Lake Mariam Dr Winter Haven, FL 33884

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 49227 Based on observations, interviews and record reviews, the facility failed to protect residents' right to be free from sexual abuse by a resident. Three residents (#2, #4, #8) of five with physician-signed lack of capacity to consent documents experienced sexual abuse in the facility. Resident #1 had a documented history of inappropriately touching and attempting to kiss staff beginning August 25, 2023. The facility did not respond with interventions that prevented sexual abuse from occurring to vulnerable residents. On 9/5/23 Resident #4 was discovered naked in their room with another resident (Resident #1). On 3/29/24 staff observed a resident (Resident #7) removing his hand from Resident #8's pants. On 4/15/24 during the 3:00 p.m. to 11:00 p.m., shift staff observed Resident #1 masturbating while Resident #2 watched standing in his room's doorway. Facility staff did not respond to this observation. On 4/16/2024 Resident #2 was observed in bed with another resident (Resident #1) standing next to the bed, his penis in her mouth. Applying the reasonable person concept to Residents #2, #4, and #8 due to their severe cognitive impairments, they would be expected to be distressed and/or afraid after non-consensual or coerced sexual contact. These failures created situations that resulted in a worsened condition for Residents #2, #4, and #8 and the likelihood for continued sexual abuse to these and other residents and resulted in the determination of Immediate Jeopardy that began on 1/26/2024. The findings of Immediate Jeopardy were determined to be removed on 5/17/2024 and the severity and scope was reduced to E after verification of removal of immediacy of harm. Findings Included: (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with Staff E, CNA, on 5/15/24 at 1:38 p.m. Staff E, CNA, stated she knew Resident #1 prior to the incident on 4/16/24 with Resident #2. Staff E said while completing shift change rounds with Staff T, CNA, Resident #1 was observed going across the hallway into Resident #2's room. Staff E, CNA, said when she entered Resident #2's room, Resident #2 was sucking his [Resident #1's] thing, and he was so into it he didn't know I was there, I yelled at him to stop. Resident #2 was observed in the B-bed laying on her side, the bed was raised to [Resident #1's] waist . He [Resident #1] had his hand behind his head. I [had] never seen it before that and haven't seen that since. Staff E, CNA, said It was like she [Resident #2] never had a reaction; she went back to sleep, she did not react. Resident #1 didn't say anything to Staff E, CNA, and Staff T, CNA. The Unit Manager, Staff U, Licensed Practical Nurse (LPN), said to Resident #1 I thought you stopped doing that, and he [Resident #1] stated No, I've never stopped that. Staff T, CNA, told Staff E, CNA, she observed the night before [April 15, 2024] Resident #1 was ejaculating and Resident #2 was watching. Attempts were made to telephone Staff T, CNA, messages left, and no response received. An interview was conducted with Staff R, CNA, on 5/15/24 at 1:57 p.m. Staff R, CNA, said she typically works on the first floor [Memory Unit] and is familiar with Resident #1 and Resident #2. He [Resident #1] has a habit of being sexual. Yesterday [Resident #1] was playing with self in room in his bed. [I] have seen him standing naked. On 4/16/24 Staff R, CNA, was assigned to care for Resident #1 and Resident #2 on the 7:00 a.m. to 3:00 p.m. shift. Staff R, CNA, said at approximately 2:00 p.m. after providing care to Resident #2, she observed Resident #1 sitting on the side of his bed and left both room doors open. Staff R, CNA, heard Staff T, CNA, ask Resident #1 What are you doing? Staff R, CNA said she went to Resident #2's room and was told Resident #1's penis was in the mouth of Resident #2. She observed Resident #2 covered with a cloth bed pad. Staff R, CNA, said Staff T, CNA, told her on 4/14/24 during the 3:00 p.m. to 11:00 p.m. shift Resident #2 was peeking in the door and Resident #1 who was sitting on his bed with pants down and he was playing with himself. Staff R, CNA said Staff T, CNA, said she told the nurse of her observation of Resident #1 and Resident #2. Staff R, CNA, heard Resident #1 tell Staff U, LPN, I can't stop, I don't want to. Staff R, CNA, said when assigned to 1:1 observation (staff supervision requiring constant visualization of the resident) for Resident #1 would be sexual and would come and stand over me. Staff R, CNA, said when assigned to hall monitoring, she received safety check logs from the hall monitor on the previous shift. Each resident on every 15 minutes, every 30 minute or every 1 hour checks will have separate logs. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted on 5/15/24 at 2:34 p.m. with Staff C, Social Services Director (SSD), who said she was familiar with the 4/16/24 incident involving Resident #1 and Resident #2. Staff C, SSD, said she spoke with Resident #2 and asked, If she was ok, remembered anything happen. Resident #2 said She was in pain but did not report area. We sent her to the hospital on the same day and they sent her back. Staff C, SSD, said she spoke with Resident #1 to find out what he was thinking before going deep into investigation. When Resident #1 was asked why he did it, he said because he wanted to. After the incident, she completed a psychosocial evaluation on Resident #1 and Resident #2 and contacted family members for each resident. Resident #2's family member did not want to press charges. Staff C, SSD, said she assumed a full-time employee position at the facility in late February 2024. She did not know Resident #1's history and he was not discussed during the transition by the previous Social Services staff. Staff C, SSD, said Resident #1 had been discussed in Quality Assurance Performance Improvement meetings (QAPI) and the following interventions had been implemented: 1:1 monitoring, room changes and hallway changes. I know right now he's 1:1, prior to this [4/16/24] incident he was referred for transfer to other facilities. During the interview with Staff C, SSD, Staff D, LPN, Staff Development Coordinator (SDC) said, no one wants him [Resident #1], family wants to keep him on 1:1 forever. Staff D, LPN, SDC, said according to Resident #1's family, elopement risk was the reason for his admission to the facility. Resident #1's family member doesn't want anything to do with him and hasn't been forthright with any information. Staff C, SSD, said I did the psychosocial evaluation with Resident #8. I notified Resident #8's family member of the incident on 3/29/24. Resident #8's family did not want the [resident] in the solarium without facility staff. Staff C, SSD, said when Resident #8 was asked about the incident, there was no response. During the interview on 5/15/24 at 2:34 p.m. a situation between Residents #7 and #4 was discussed, Staff C, Social Services Director (SSD) said when Resident #7 was asked about the incident, the resident did not admit the incident occurred. Staff C, SSD, said 1:1 monitoring of Resident #7 was started immediately. Staff C, SSD, said Resident #4 does not remember anything from September. Resident #4 hangs out with others from the same culture and communicates in her [native language]. Resident #2 Review of Resident #2's admission record revealed initial admission to the facility was on 6/4/2023 with diagnoses of Parkinson's disease, major depressive disorder, heart failure, chronic kidney disease, dementia, hyperlipidemia, high blood pressure, encephalopathy, and dysphagia. Review of Resident #2's Minimum Data Set (MDS), quarterly dated 12/4/23, revealed a Brief Interview for Mental Status (BIMS) score of 4 out of 15, meaning severe cognitive impairment. Section GG for Functional abilities and goals revealed Resident #2 uses a wheelchair for mobility. Review of section E, Wandering - Presence and Frequency revealed Resident #2 wanders daily. Review of section J, Prognosis revealed Resident #2 has a medical condition or chronic disease that may result in a life expectancy of less than 6 months. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a care plan, created on 6/6/23, revealed Resident #2 has impaired cognitive function/dementia or impaired thought processes related to dementia, impaired decision-making, long-term memory loss, short term memory loss. The care plan's goal is Resident #2 will maintain current level of cognitive functioning. Review a of care plan, created on 2/26/24, revealed Resident #2 is receiving hospice services due to terminal diagnosis of Parkinson's disease. The care plan's goal is to keep Resident #2 comfortable throughout the end-of-life journey. Review of a care plan created on 3/4/24, revealed Resident #2 has a terminal condition related to Parkinson's disease. The care plan's goal is Resident #2's comfort to be maintained. Review of care plan, Resident #2 is at risk for cardiovascular complications related to congestive heart failure and high blood pressure. The care plan's goal is Resident #2 will have minimized complications related to cardiac (heart) condition. Review of the care plan created on 6/23/23, revealed Resident #2 at times wanders but is usually easily redirected to the nurses' station or day activities. The care plan's goal is Resident #2's safety will be maintained through next review date. Review of a care plan created on 9/17/23 revealed Resident #2 is impulsive and pulls wheelchair behind her difficult to redirect. The care plan's goal is Resident #2 will cooperate with care through the next review date. Review of order summary report revealed physician orders active as on 5/13/24 included 1) actively exit seeking, record number of occurrences every shift; 2) Hospice services for Parkinson's disease; 3) Trazodone for depression; 4) Metoprolol for Hypertension; 5) Morphine Sulfate 20 mg/ml (milligrams per milliliter) by mouth every 6 hours when needed for pain ; 6) Ativan 1 mg for anxiety every 4 hours as needed. Review of Resident #2's Determination of Incapacity, dated 4/5/24, and signed by two providers, revealed . resident lacks capacity to give informed consent to make medical decisions and does not have reasonable probability of recovering mental and physical capacity to directly exercise rights. Review of a psychiatric note, authored by the psychiatric-mental health nurse practitioner (PMHNP), dated 4/2/24. The history of present illness section revealed no reports of anxiety symptoms .no behaviors reported at this time. Resident #2's mental status examination section revealed the following: Appearance/ behaviors: confused. Mood: Patient mood is fine Affect: constricted Insight judgement: Impaired The plan of action section revealed continue medications, lorazepam for agitation intramuscularly (IM) three times daily as needed (PRN) for the next two weeks. Review of a subsequent psychiatric note, authored by the PMHNP, dated 4/17/24, section history of present illness revealed Prior to last visit, patient was doing well. Patient was not depressed or anxious. Patient had no behaviors reported. During the last visit, patient had no distress noted unit manager and director of nursing (DON) requested resident to be [evaluated] via tele psych due to patient having increase agitation and combativeness. Patient appeared irritable. Resident #2's mental status examination section revealed the following: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Appearance/ behaviors: Well groomed, poor eye contact Mood: Patient mood is irritable Affect: Tensed Insight judgement: Impaired The sectioned titled assessment and plan revealed patient is unstable requiring medication changes . symptoms are occurring due to exacerbation of underlying .mood disorder. the symptoms occurring almost daily causing severe distress. The start medication section revealed Trazadone 25mg three times daily. On 5/13/24 at 9:48 a.m. during observation and interview, Resident #2 was found lying on her left side, linen up to her shoulders. Resident #2 opened her eyes when greeted, and nodded when asked if she was feeling okay. She did not respond verbally during the interaction. On 5/14/24 at 2:45 p.m. Resident #2 was observed in bed with her eyes closed. She appeared calm without any indication of pain or discomfort. On 5/17/2024 at approximately 3:40 p.m. Resident #2 was observed waking and was accompanied back to her wheelchair by staff. Review of a progress note, dated 4/17/24 at 10:42 p.m. authored by Staff CC, RN, revealed . Lorazepam was administered due to agitation. Review of Resident #2's facility progress note, dated 4/18/24 at 12:26 p.m. authored by Staff U, LPN, revealed resident noted very agitated refusing care combative Ativan 0.5 mg IM resident placed in crisis care by hospice with 24 hours at bedside. Review of Resident #2's facility progress note, dated 4/19/24 at 9:21 p.m. authored by Staff CC, RN, revealed . resident had increased agitation during the shift. Lorazepam 1 mg administered .to decrease agitation. Review of Resident #2's facility progress note, dated 4/23/23 authored by Staff EE, LPN revealed new order was given by the hospice nurse Lorazepam (Ativan) 1mg every four hours and d/c (discontinue Lorazepam 0. 5 mg). Review of Resident #2's eINTERACT SBAR Summary for Providers note dated, 4/16/24 at 6:25 p.m., authored by Staff U, LPN, Unit Manager, revealed the change in condition (CIC) being reported is: other change in condition, and lists vital signs from 4/16/24 at 6:31 p.m. The section titled Outcomes of Physical Assessment revealed: Mental Status evaluation: No changes observed. Functional status evaluation: No changes observed. Behavioral status evaluation: No documentation Nursing observations, evaluation, and recommendation resident to resident altercation MD order resident out evaluation. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident # 2's progress notes, dated 4/16/24 at 5:00 p.m., authored by Staff C, SSD, revealed, resident was interviewed by writer and does not have memory of a male being in her room or a memory of anything happening to her .verbalized she was not feeling well and was in pain. Review of Resident # 2's progress notes, dated 4/16/24 at 4:02 p.m., authored by Staff DD, RN, revealed tele health done, no new orders. A review of Resident #2's Emergency Department Discharge instructions, dated 4/15/24, section titled, Tests Performed, revealed blood tests for hepatitis and HIV screen were performed. Section titled: Education Material revealed Treating sexual assault. Resident #4 Review of Resident #4's admission record revealed the initial admitted was on 8/11/23 with diagnoses including gastroesophageal reflux disease, hyperlipidemia (high fat content in the blood), dementia, mood disturbance, Alzheimer's disease, cerebral atherosclerosis (buildup of plaque in the artery) major depressive disorder, generalized anxiety disorder, other persistent mood disorders and brief psychotic disorder. Review of Resident #4's Minimum Data Set (MDS), quarterly dated 4/21/24, revealed a Brief Interview for Mental Status (BIMS) score 1 out of 15 meaning severe cognitive impairment. Section GG for Functional abilities and goals revealed Resident #4 walks independently and is dependent with personal hygiene. Review of Resident #4's Determination of Incapacity, dated 2/2/24, and signed by two providers revealed . resident lacks capacity to give informed consent to make medical decisions and does not have reasonable probability of recovering mental and physical capacity to directly exercise rights. On 5/13/24 at 11:30 a.m. Resident #4 was observed sitting on the side of her bed. English is a second language for Resident #4 and an interpreter was used for communication. Resident #4 said she was doing well and did not have any concerns. On 5/114 at 2:15 p.m., Resident #4's family member was contacted by telephone and said they would return the phone call with another family member due to language barrier. A return call was not received. Review of Order Summary Report active orders as of 5/15/24 reveal Resident #4: 1) actively exit seek, record interventions. admitted to hospice on 10/23/23 related to diagnosis of cerebral atherosclerosis. 2) Attest that rounding with visualization of resident has been completed every two hours during the shift, ordered on 8/22/23. Resident #4's Depakote for mood disorder, Trazadone for depression, Paxil for depression, Zonisamide for seizures, and Olanzapine for psychosis. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the care plan focus created on 8/14/23 revealed Resident #4 had potential for pain related to muscle weakness and terminal prognosis, and the care plan's goal was Resident #4 will not experience a decline in overall function. A care plan created on 8/20/23 revealed Resident #4 was at risk for complications due to being incontinent of urine and bowel. At risk for developing areas of impaired skin integrity and UTIs (Urinary Tract Infections). The goal was to minimize Resident #4's risk for skin breakdown and infection. A care plan created on 8/14/23 revealed Resident #4 was an elopement risk/wanderer related to impaired safety awareness, resident wanders aimlessly. The care plan's goal was Resident #4's safety will be maintained through the next review date. A review of the care plan created on 8/13/23 revealed Resident #4 had potential to be physically aggressive related to dementia, history of harm to others, poor impulse control, and inappropriate behaviors. The care plan goal was Resident #4 will not harm self or others through the next review date. A review of the care plan created on 8/14/23 revealed Resident #4 had impaired cognitive function/dementia or impaired thought processes related to dementia, impaired decision making, and short-term memory loss. The care plan goal was Resident #4 will maintain level of cognitive function through the review date. A review of Resident #4's care plan focusing on impaired thought process related to dementia, impaired decision making and short-term memory loss, initiated on 8/14/23, stated the care plan goal was resident will maintain the current level of cognitive function through review date. The care plan interventions include cue, reorient and supervise as needed. A review of Resident #4's progress note dated 9/5/23 at 11:25 p.m. revealed .Resident was observed by staff in room with [Resident #1], at this time resident was without clothing, resident was redirected .family member and physician notified. Resident #8 Review of Resident #8's admission record revealed initial admission to the facility was on 6/29/20 with diagnoses of cerebral atherosclerosis, depression, dementia, psychotic disturbance, anxiety, pseudobulbar affect (condition that affects how the brain controls emotion), high blood pressure, type 2 diabetes, pressure ulcer (sore) right hip. Review of Resident #8's active orders as of 5/14/24 revealed: 1) hospice services effective 7/6/23 for cerebral atherosclerosis. 2) attest that rounding with visualization of resident every 2 hours. 3) Hydrocodone with acetaminophen every 12 hours as needed for pain. 4) Levothyroxine for hypothyroidism. 5) Trazodone for depression. Review of Resident #8's Minimum Data Set (MDS) quarterly, dated 4/5/24, revealed a Brief Interview for Mental Status (BIMS) score of 99, meaning severe cognitive Impairment. Section F, Preferences for Customary routine Activities, revealed Resident #8 is rarely/never understood and family/significant is not available. Section GG, Functional Abilities and Goals, reveals Resident #8 uses a wheelchair and is dependent on staff for mobility and self-care. On 5/14 at 3:17 p.m. Resident #8 was observed sitting in a Geri chair by the nurses' station. Her eyes were open; she did not react to greetings or respond to questions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #8's Determination of Incapacity, dated 6/8/20, and signed by two providers, revealed . resident lacks capacity to give informed consent to make medical decisions and does not have reasonable probability of recovering mental and physical capacity to directly exercise rights. Review of care plan focus revealed Resident #8 was at risk for skin breakdown. The care plan's goal was Resident #8's Risk for skin breakdown will be minimized through next review. Review of care plan focus revealed Resident #8 had a pressure wound to right hip. The care plan goal was Resident #8 wound will heal without complications. Review of care plan revealed Resident #8 had diabetes and was at risk for high and low blood sugars. The care plan's goal was Resident #8 will remain free from complications related to high and low blood sugars. Review of care plan focus revealed Resident #8 was at risk for decreased ability to perform activities of daily living in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting. The care plan goal revealed Resident #8 will continue to participate in activities of daily living as tolerated. Review of care plan revealed Resident #8 had the potential for pain related to wound, diabetes and depression. The care plan's goal was Resident #8 will not experience a decline in overall function. Review of care plan focus revealed Resident #8 was at risk for complications due to being incontinent of urine and bowel related to impaired cognition and impaired mobility. The care plan goal was Resident #8 will minimize the resident's risk of skin breakdown through the next review date. Review of care plan focus revealed Resident #8 was receiving Hospice services as of 7/6/23 for diagnosis of cerebral atherosclerosis. The care plan goal was Resident #8 will be kept comfortable throughout the end-of-life journey. Review of care plan focus revealed Resident #8 had a terminal condition related to cerebral atherosclerosis. The care plan's goal was Resident #8's comfort will be maintained through next review date. Review of care plan focus revealed Resident #8 had impaired cognitive function/dementia or impaired thought processes related to dementia. The care plan goal was Resident #8 will maintain current cognitive function through review date. Review of Resident #8's Psychiatry Subsequent Note, authored by the psychiatric-mental health nurse practitioner (PMHNP), date of service (DOS) 3/29/24, the History of Present illness section, revealed . as per collected information, DON requested patient to be seen as patient was touched by a male patient. Patient did not respond to providers questions but appears to be lying comfortably with eyes open. No noted signs or symptoms of distress. No other psychiatric symptoms observed. Dementia is persistent, but no behaviors noted. The Mental status examination section revealed; Appearance/ Behaviors: calm, Mood: stable, Affect: appropriate, Insight and Judgement: Impaired. The Plan of action section revealed no medication changes. Resident #1 Review of Resident #1's admission record revealed initial admission to the facility was on 6/22/2023 with diagnoses of Syncope and collapse, Hyperlipidemia, Dementia, Anxiety Disorder, Depressive Disorder, Persistent Mood Disorders, Insomnia, Essential hypertension, Muscle weakness and bradycardia. Review of Resident #1's Determination of Incapacity, dated 3/7/24, and signed by a provider revealed . resident lacks capacity to give informed consent to make medical decisions and does not have reasonable probability of recovering mental and physical capacity to directly exercise rights. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's Minimum Data Set (MDS) quarterly, dated 3/22/24, revealed a Brief Interview for Mental Status (BIMS) score of 7 out of 15, meaning moderate cognitive Impairment. Functional Abilities revealed he was independent in walking and transferring from bed to chair. Behaviors showed he had verbal behaviors directed towards others and other behavioral symptoms. He exhibited wandering in the past one to three days. Review of the Facility's progress notes, order summary report and interviews for Resident #1 revealed the following: 7/19/23 transferred to the facility's memory unit due to behaviors. Resident #1 was reported to inappropriately touch and attempt to kiss staff. On 9/5/23 Resident #1 and Resident #4 were observed naked in Resident #1's bedroom. On 9/6/23 he was moved to a room on the opposite hallway away from Resident #4. On 9/8/24 Depakote 250 mgs was prescribed for mood disorder. On 11/6/23 and 12/16/23 Resident #1 had physical and verbal altercations with other residents. On 12/17/23 Resident #1's room was changed due to the 12/16/23 altercation with his roommate. On 2/6/24 resident was redirected because of inappropriate conversation with a female resident. On 2/7/24 Resident #1 was observed exhibiting inappropriate sexual behaviors. On 3/5/24 Resident #1 was observed following a female resident, when redirected he became agitated and said, he can if he wants to. On 4/15/24 Resident #1 was masturbating while Resident #2 was watching. On 4/16/24 Resident #1 was observed in Resident #2's room engaged in oral sex. Review of Resident #1's care plans revealed the following focus Resident #1 is at risk for hypersexual behaviors. Resident is inappropriate at times with others, initiated on 10/13/2023. The care plan goal was Resident #1 will be free from inappropriate sexual behaviors through next review, initiated on 10/13/2023. The interventions included medication adjustments, initiated on 12/21/23. Monitor each shift for inappropriate sexual behaviors, initiated on 10/13/23. Resident 1:1 supervision, initiated on 4/17/24. Review of Resident #1's care plans revealed the following focus Resident can be sexually inappropriate with others, initiated on 7/5/23 and revised on 4/30/24. The goal was Resident #1 will cooperate with care through next review date, initiated on 7/5/23. The interventions included psych consult with medication adjustments, initiated on 9/8/23. Review of Resident #1's care plans revealed the following focus: Resident #1 has poor impulse control, initiated on 11/6/23. The goal is Resident will not harm self or others through review date, initiated on 11/6/23. The interventions included psychiatric/psychogeriatric consult as indicated, initiated on 11/6/23. Redirect others as needed from his room, initiated 11/14/23. Review of Resident #1's care plans revealed the following focus: Resident #1 has impaired cognition impaired decision making, initiated on 6/26/23. The goal was Resident will maintain current level of cognitive function through the review date, initiated on 6/26/23. The interventions included cue, reorient and supervise as needed, initiated on 6/26/23. Review of the facility's care plan meeting minutes quarterly, dated 4/9/24, revealed 4 signatures for the team members in attendance. The Discussion section listed the following: Discharge Plans: Long Term Care (LTC) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105428	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Mariam Health and Rehabilitation Center	1801 N Lake Mariam Dr Winter Haven, FL 33884

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Advanced Directive: Full Code incapacity Acute Medical Conditions: No documentation Chronic Medical Conditions: hypertension (HTN) and hyperlipidemia Skin/ Wound Conditions: Within Normal Limits (WNL) Nutrition/ Hydration: Regular thin liquid Bowel/ Bladder: Continent Rehabilitation Service: No documentation Physical Function: requires assist to complete ADL's. Behavioral Health/ Activities: No documentation Resident/ Family Concerns: No Documentation Review of Resident #1's Order Summary Report, Active orders as of 5/13/24 revealed the following: 1:1 supervision every shift, start date 4/30/24 Observe sexual behaviors. Document 'Y' if resident has behaviors and 'N' if the resident does not have behaviors. If 'Y' document in the progress notes (PNs) and notify provider, start date 4/30/24. Depakote 250 mg three times daily for mood disorder. Estradiol 2 mg twice daily for hypersexual behaviors Lithium 150 mg twice daily for mood disorder, the start date is 5/11/24. Paroxetine 20 mg daily for Major Depressive Disorder (MDD) Trazodone 50 mg for depression. Review of Resident #1's facility progress note, dated 8/24/23 at 2:29 p.m. authored by Social Services, revealed notified by staff resident has been inappropriate at times, attempts to hit them on butt and has attempted to kiss them. Review of Resident #1's facility progress note, dated 9/5/23 at 9:32 p.m. authored by Staff FF, LPN, revealed Resident is alert, resident was observed with a female resident in his bed. Resident was not dressed he was redirected to get dressed . [family member] was informed of incident and that there will also be a room change . MD was notified. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's facility progress note, dated 9/5/23 at 10:17 p.m. authored by Staff GG, LPN, revealed Resident is alert oriented able to make needs known, Resident was observed by staff in a female resident room with missing clothing, resident was redirected, call was placed to [family member] to inform her of current situation, .MD notified .room was changed and staff to constantly monitor resident and redirect as needed. Review of Resident #1's facility progress note, dated 11/6/2023, Nursing, revealed, Resident pushed another resident from his room to the floor on the hallway floor. Resident's family member and MD aware, psych consult, increase Trazadone 25 mg po bid and 50 mg po [milligrams by mouth twice a day] at night, resident stated he is not sleeping at night. Review of Resident 1's facility progress note, dated 12/16/2023, Nursing, revealed, Resident became aggressive towards roommate, started yelling and cursing because roommate stated he was wearing his clothes. Review of Resident1's facility progress note, dated 12/17/2023, Nursing, revealed, Resident had a room change. Review of Resident #1's progress note, dated 2/7/2024 at 9:02 a.m., Social Service Note, Resident was noted to exhibit inappropriate sexual behaviors. Resident was redirected and was currently on every hour checks. Psych was notified for consult. MD was notified regarding behaviors. Resident will be placed on 1:1 observation with staff. Review of Resident #1's progress note dated 3/5/2024 at 8:58 a.m., Nursing, revealed Resident observed following a female resident, when redirected he became agitated and said, he can if he wants to. Review of Resident #1's facility progress note, dated 4/16/24 at 4:08 p.m. authored by Staff FF, LPN, revealed Resident is alert, resident was observed in another resident room inappropriate sexually with another resident. Resident told staff he had no regrets, Resident was removed from the situation and placed on 1:1 supervision. [family member] and MD notified. Review of Resident #1's Medication Administration Record/Treatment Administration Record, dated April 2024, revealed sexual behaviors were observed 4/15/24, on the night shift and 4/22/24 on the day and night shifts. Review of resident #1's progress notes dated 4/15/24 and 4/22/24 did not describe the behaviors or if the medical team was notified as ordered. Review of a Psychiatry Subsequent Note, authored by the psychiatric-mental health nurse practitioner (PMHNP), date of stay (DOS) 4/5/24 revealed the following: The Reason for Today's encounter: .medication management, Mental Status Exam: Appearance Behaviors: Disheveled Mood: Patient mood is okay Affect: Appropriate Insight and Judgement: Impaired (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The summaries section revealed the following: On 7/7/23 the patient is at base line, no medication changes. On 7/21/23 the patient was referred to neurology On 8/25/23 discontinued Zoloft, started Trazadone 25 mg three times daily and Estradiol 1 mg daily. On 9/8/23 started Depakote 250 mg twice daily On 11/6/23 Increased Trazadone to 25 mg in the morning and at noon and 50mg at bedtime. Discontinued 1:1 sitter. On 2/9/24 Patient has sexually inappropriate behaviors. On 4/5/24 Patient is at baseline, no medication changes. Plan of action .Depakote is needed for mood disorder, Estradiol to control symptoms of sexual disinhibition and Trazadone for manag [TRUNCATED]