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	03/12/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed 1) to report abnormal radiology results to the provider and complete an assessment and change in condition for a resident with respiratory distress for one resident (#7) out of six residents sampled, 2) to ensure laboratory orders were entered in the electronic laboratory (lab) portal and completed as ordered for two residents (#7, #1) out of six residents sampled and 3) to ensure timely administration of an antibiotic for one resident (#1) out of three residents sampled. Resident #7's laboratory orders were not completed as ordered, the abnormal radiology results were not reported to the doctor, and an assessment and change in condition were not completed and Resident #7 suffered a cardiac arrest. These failures created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to residents and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the scope and severity was reduced to a D after verification of removal of immediate jeopardy.Cross reference F773.Findings included: 1.An interview was conducted on [DATE] at 3:53 p.m. with Staff M, Certified Nursing Assistant (CNA). Staff M said she knew Resident #7 very well. She said on her shift from 11:00 p.m. on [DATE] through 7:00 a.m. on [DATE] Resident #7 was not herself. Staff M said she had helped the resident to bed after she was up walking around and she knew the resident was not right. Staff M said she kept a close eye on the resident. She said around 4:00 a.m. she saw Resident #7 sitting on the side of her bed gasping for air. Staff M said she told Staff I, Licensed Practical Nurse (LPN) something was wrong with the resident, and she was gasping for air. Staff M said Staff I told her the resident probably just had the hiccups. Staff M said the nurse then went to Resident #7's room and tried to take vital signs but was unable to get a pulse or oxygen saturation (O2 sats) reading due to the resident's hands being too cold. Staff M said she was told to warm up with resident's hands and they would try again. Staff M said she told the nurse she thought Resident #7 needed to be sent to the hospital, but nothing else was done for Resident #7. Staff M said when she left at the end of her shift that morning ([DATE]), she told a CNA who was working the day shift to keep an eye on Resident #7 because she was not doing good. Staff M said when she returned in the evening at approximately 10:45 p.m. on [DATE] for her next shift that CNA told her Resident #7 was not the resident they knew. Staff M said she went to Resident #7's room around 11:00 p.m. to check on her. She said Resident #7 was lying down and not responding. She said the resident was breathing and had a faint pulse but was unresponsive. Staff M said she yelled out for a nurse and Staff I, LPN was the only nurse on the unit, so she came down to help. Staff M said Staff I, LPN tried to get vital signs and could not get any readings. Staff M said Resident #7 did not have any oxygen in place at the time and the oxygen concentrator in her room was not even plugged in. Staff M said she alerted Staff I, LPN to the resident's tongue hanging out of her mouth. Staff M said she got oxygen turned on and placed on the resident and Staff I, LPN called a code. Staff M said the resident stopped breathing and lost a pulse and staff performed CPR until Emergency Medical Services (EMS) arrived. Review of admission Record showed Resident #7 was admitted on [DATE] with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	gastro-esophageal reflux disease without esophagitis, essential (primary) hypertension, and generalized anxiety disorder. Review of Resident #7's Quarterly Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) could not be conducted due to the resident rarely/never being understood. Review of Resident #7's Care plan showed a focus area of risk for cardiovascular complications related to (r/t) hypertension, dated [DATE]. Interventions included monitor for shortness of breath (SOB), chest pain, bradycardia, hypotension, tachycardia, hypertension, increased edema, weight gain, etc. report any significant abnormalities to the medical doctor. Review of Resident #7's physician orders showed: -O2 (oxygen) via nasal cannula at 2 Liters (L) for SOB (shortness of breath). Dated [DATE]. -STAT (immediate) Complete blood count (CBC) (a common blood test that measures red/white blood cells, hemoglobin, hematocrit, and platelets to evaluate overall health, diagnose symptoms and detect infections) and comprehensive metabolic panel (CMP) (a blood test that measures key indicators of kidney and liver health, electrolytes, blood sugar, and protein levels). Dated [DATE] at 11:13 a.m.-STAT chest x-ray 2 view for SOB. Dated [DATE]. -Ipratropium-Albuterol Solution 0.5-2.5 (3) milligram (mg)/3 milliliter (ml). 3 ml inhale orally via nebulizer every 6 hours every 5 days for SOB. Dated [DATE]. -Full Code. Dated [DATE]. An interview was conducted on [DATE] at 12:43 p.m. with Staff I, LPN. Staff I said Staff M, CNA did speak to her on the overnight shift from 2/15-[DATE] about Resident #7 not breathing normal. She said she went to the resident's room looked at her and thought she was fine. Staff I said she thought the resident just had the hiccups or something. Staff I said she tried to take the resident's vital signs, but her hands were cold so she could not get a reading. She said she just kept an eye on the resident. Review of Resident #7's medical records did not show documentation of an assessment, change in condition or progress note related to the breathing concerns brought to Staff I, LPN's attention by Staff M, CNA. Review of Resident #7's progress notes showed: -[DATE] 12:00 p.m. Narrative Note (General) Late Entry: Created [DATE] 3:03 p.m. by Staff K, LPNResident is showing signs of shortness of breath, slightly labor [EH1.1][sic] breathing, oxygen reading at seventy three on room air. MD [Medical Doctor] notified ordered oxygen at two liters, stat chest x ray, stat cmp, neb [nebulizer] tx [treatment] and cbc and UA/CS [urinalysis/culture and sensitivity]. Guardian called voicemail left. Resident is in bed at this time with oxygen at 2L. The resident has to be redirected to keep nasal cannula in place. Bed is in the lowest position and call light is within reach.An interview was conducted on [DATE] at 2:36 p.m. with Staff K, LPN. Staff K said she took care of Resident #7 during the 7:00 a.m. to 3:00 p.m. shift on [DATE]. She said Resident #7 seemed okay other than her breathing being a little off if you really looked at her. She said the resident had light labored breathing and a runny nose. Staff K said she knew the flu or something had been going around the facility, so she checked her oxygen saturation, and it was low. Staff K said she texted Resident #7's primary care provider (PCP)/Medical Director letting him know the resident's oxygen saturation was 88% and asked for oxygen orders. Staff K said she did not get a response from the PCP, so she went ahead and placed oxygen on the resident. She said not long after that the PCP's Advanced Registered Nurse Practitioner (ARNP) came in and ordered STAT labs and x-ray. Staff K said STAT labs had to be put into a lab website and Staff P, Registered Nurse RN/Unit Manager (UM) put the labs in the site for her. Staff K said she administered the breathing treatments the ARNP ordered for Resident #7 and had to stand and watch her because she would not keep the mask on and would not keep her nasal cannula on either. Staff K said she honestly thought Resident #7 had a cold or whatever else was going around the facility.Review of Resident #7's medical records did not show any lab results from [DATE]. An interview was conducted on [DATE] at 1:00 p.m. with the laboratory company for the facility. The lab looked up Resident #7's record and said they did not show a phone call or requisition ticket entered for STAT labs on [DATE]. They said no labs were drawn for Resident #7 on [DATE]. The lab representative said if STAT labs are ordered the nurse had to go to their website and create a ticket with the lab requisition and mark that they were ordered STAT. They said the ticket being created triggered the STAT lab process. The lab said STAT labs are drawn (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	between 75-90 minutes after the ticket is created and resulted within four hours. Review of Resident #7's chest x-ray reported to the facility on [DATE] at 2:37 p.m. showed: FINDINGS:The heart is enlarged.Mild indistinct pulmonary vascularity with peribranchial cuffing.There are no focal infiltrates. Slightly elevated right dome of diaphragm again noted.No evidence of pleural effusions.No evidence of the pneumothorax.No acute osseous findings.IMPRESSION:Cardiomegaly and suggestion of mild pulmonary venous hypertension. No focal infiltrates. Slightly elevated right dome of diaphragm redemonstrated. No active pulmonary tuberculosis.There is interval worsening of pulmonary congestion noted.Review of Resident #7's medical records did not show any documentation a provider was notified of the chest x-ray results on [DATE] that were completed at 2:37 p.m. Review of Resident #7's progress notes showed: [DATE] 12:41 a.m. Narrative Note (General) by Staff I, LPN This writer was just on coming for night shift and performing walking round. oncoming CNA called for a nurse to [Resident #7's room]. Upon arrival to the room, the resident was observed laying on her bed. she was very pale and had gasping breaths. This writer obtained vitals BP [blood pressure] 96/60, p [pulse] 58, RR [respiratory rate] 4-6 bpm, O2 sat 73% on O2@2l. The resident's eyes then closed and respirations ceased. This writer performed sternal rub with no response from resident. lost pulse and O2 sat. Sent a CNA to check code status. Was advised resident is full code. This writer called code blue at [11:09 p.m.]. this writer initiated chest compressions and CPR at [11:10 p.m.]. this writer delegated code notes to CNA. Other staff arrived. Another nurse called 911 at [11:11 p.m.]. other staff arrived to assist this writer and cna [sic] with break from CPR. [11:18 p.m.] CPR paused to check for vitals resident had no pulse and no respirations. CPR resumed and continued with the dispatcher on the phone guiding until EMS arrived at [11:20 p.m.]. 2 nurses and 3 CNA performed CPR in Rotations until EMS came and took over the code. Resident transferred to stretcher and taken to [Hospital] on stretcher and with EMS via ambulance at [11:33 p.m.]. Call placed to resident guardian and message left of resident transfer to hospital at [11:46 p.m.]. MD notified of code blue and transfer to [Hospital] at [11:51 p.m.].An interview was conducted on [DATE] at 1:14 p.m. with Staff I, LPN. Staff I said she came on shift on [DATE] and counted medications with the off-going nurse. She said she got there around 10:45 p.m. and she saw Staff L, LPN, the off-going nurse for Resident #7. She said she started her room rounds and was about halfway through when she heard Staff M, CNA yelling nurse. Staff I said she was the only nurse on the unit at the time because Staff L had left and her replacement wasn't there yet and when she got to Resident #7's room and the resident did not look good. She said the resident did not have oxygen on, so staff quickly put the resident's nasal cannula on and checked her O2 sats. She said Resident #7's oxygen saturation was 73%. Staff I said the resident kept trying to pull the nasal cannula off. She said then the residents heart rate and oxygen dropped to 0 and the resident went limp and her eyes closed. Staff I said she started CPR. She said CPR continued until EMS arrived. Staff I said she did not hear there was any issue with the resident prior to the CNA yelling for the nurse and her going down to check on the resident and do CPR. An interview was conducted on [DATE] 1:27 p.m. with the PCP/Medical Director. He said he was not notified of Resident #7's chest x-ray result on [DATE]. After review of results he said he would have given treatment orders immediately if he had been notified. He was unaware the STAT labs were not completed for Resident #7 and said they should have been. The PCP/Medical Director said to confirm with his partner physician to ensure she had not been notified of the results as one of the two of them should have been.An interview was conducted on [DATE] at 1:45 p.m. with the PCP/Medical Director's partner physician. She said she was not notified of the chest x-ray results for Resident #7 on [DATE]. After reading the results she said a provider should have been notified and treatment put in place.An interview was conducted on [DATE] at 3:10 p.m. with the PCP/Medical Director's ARNP. The ARNP said she ordered the STAT labs and chest x-ray for Resident #7 on [DATE], but she was not notified of the results, and she was not aware the resident's STAT labs were not completed as ordered. The ARNP said her expectation is for orders to be completed and the nurse to call with results when they come in. The ARNP reviewed Resident #7's chest x-ray results (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and said if she had seen those, she would have given new treatment orders for the resident. An interview was conducted on [DATE] at 2:07 p.m. with the Director of Nursing. (DON). She said if a CNA tells a nurse a resident is not breathing well and is not herself, she expected the nurse to do a full assessment including listening to lungs, visual assessment, check vitals, check oxygen level, and put oxygen on the resident. She said having cold hands wouldn't matter if the nurse needed to find a way to get vitals or call 911. She then said they should document the assessment and notification to the provider and family. The DON said for the lab process the nurse should put orders in the computer, then go to the lab portal and enter the orders in the chat box for STAT orders. She said it is a new process to the nurses, and they don't seem to be doing it right. She said as soon as the labs or imaging results are back the nurse should notify the provider and document the notification in the medical record. The DON reviewed Resident #7's record and confirmed there was no documentation of notification of the STAT chest x-ray results and no lab results on [DATE]. 2.An interview was conducted on [DATE] at 3:27 p.m. with the Resident Representative (RR) for Resident #1. The RR said the week before the resident went to the hospital, he had a chest cold and on Monday [DATE] she was told by a nurse Resident #1 had run a fever on Saturday [DATE] and Sunday [DATE]. The RR said she was not notified the resident had a change in condition over the weekend. She said when she came to the facility on Monday morning, [DATE], Resident #1 was lethargic, nonresponsive, very clammy, gasping for air, and had mottling (patchy, discoloration of the skin caused by uneven blood circulation or constricted vessels) from the feet up to his mid shin. The RR said she told staff she wanted the resident sent out to the hospital immediately. An interview was conducted on [DATE] at 2:35 p.m. with Staff E, Certified Nursing Assistant (CNA). Staff E said Resident #1 came down with a cold on Thursday [DATE]. Then on Saturday [DATE] and Sunday [DATE] was worse; he was sick. She said the resident was on oxygen all weekend and was running a fever. Staff E said she was close with the resident and was able to get him to eat and drink. She said he was not drinking as much as usual, but she got him to drink a full cup of water on Sunday. Staff E said she came in Monday [DATE] at 7:00 a.m. and Resident #1 was even worse. She said the nurse that had the resident from [EH2.1]11:00 p.m. to 7:00 a.m. told her Resident #1 was probably going out to the hospital. Staff E said when the RR arrived at approximately 8:00 a.m. she said she wanted the resident sent out immediately. Staff E said Resident #1 was clammy and was working harder to breathe, but he was not gasping for air. Staff E said after the nurse administered medication, Resident #1's temperature was 101.7 and he felt warm but was not burning up hot. She said the resident was lethargic and more peaceful but was still responding to her. Review of admission Records showed Resident #1 was admitted on [DATE] with diagnoses including aphasia, apraxia, hemiplegia/hemiparesis affecting right side from cerebrovascular disease, and dementia. Review of Resident #1's Quarterly MDS dated [DATE], Section C, Cognitive Patterns, showed a BIMS couldn't be conducted due to the resident being rarely/never understood. Review of Resident #1's medical records revealed a Determination of Incapacity signed by a physician, dated [DATE]. Review of Resident #1's orders showed: -O2 at 3 L Start date [DATE]-Ipratropium-Albuterol 0.5-2.5 mg/2 ml solution. 1 vial inhale orally every 4 hours as needed for shortness of breath. Start date [DATE]-Ceftriaxone Sodium Solution Reconstituted 1 gram (g). Inject 1 gram intramuscularly (IM) one time a day for infection for 3 days. Start date [DATE]. -CBC and CMP Every night shift for labs for 1 day. Start date [DATE]. -STAT Chest X-ray 2 view r/t congestion portable due to (d/t) generalized weakness. Start date [DATE]. -Flu swab, covid swab, RSV swab, CBC, CMP one time only for SOB, respiratory. Start dated [DATE]. Review of Resident #1's February 2026 Medication Administration Record (MAR) showed Ceftriaxone was not administered on [DATE] and the order was put in the computer to start on [DATE]. On [DATE] Ceftriaxone was documented as refused. There was no additional documentation a provider or RR was called about the medication refusal. Review of Resident #1's chest x-ray on [DATE] showed:Findings: Comparison with prior study February 2, 2026Linear atelectasis seen bilaterally. Mild elevation right hemidiaphragm. No focal infiltrate or evolving mass. Mild CHF [congestive heart (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was conducted on [DATE] at 9:54 a.m. with the facility's pharmacy. The pharmacy representative said Resident #1 had Ceftriaxone 1 g x 3 doses delivered to the facility on [DATE] at 6:35 a.m. During a follow-up call on [DATE] at 1:23 p.m. they stated Ceftriaxone was not pulled from the facility's electronic medication dispensing machine on [DATE] or [DATE]. Review of Resident #1's physician orders showed a CBC and CMP order was placed on [DATE] at 12:32 p.m. by Staff H, LPN/Weekend Supervisor. The order was placed for routine labs to be completed on [DATE]. The orders did not show a flu or COVID test was ordered until Monday [DATE]. An interview was conducted on [DATE] at 3:01 p.m. with Staff G, LPN. Staff G said she worked from Sunday [DATE] 11:00 p.m. until Monday [DATE] at 7:00 a.m. She said around 11:30 p.m. Resident #1 had more congestion and was warm to touch. She said he was already on oxygen, so she texted the resident's PCP. She said the doctor explained what he had already done and ordered a repeat STAT chest x-ray. Staff G said she noticed Resident #2 had not yet been administered the ordered Ceftriaxone Sodium injection that had been ordered so she administered a dose around 1:00-2:00 a.m. on [DATE]. Staff G said she did not document she had given the medication. Staff G said the resident had a temperature of 101.2 but it went down after getting Acetaminophen. She said Monday morning Resident #1 was moaning and breathing harder. She said she had given report to the oncoming nurse and then she stayed to help get the resident sent out to the hospital. Review of Resident #1's Fire Rescue Division Run Report showed: Unit dispatched [DATE] 9:23 a.m. Arrived at patient 9:33 a.m. Depart [DATE] 9:50 a.m. At hospital [DATE] 9:54 a.m. Chief Complaint: altered mental status barely responsive to painful stimuli found by facility staff coming onto shift no last seen normal. Arrived on scene to find patient lying in bed of nursing home residents reported to have been found during morning checks and have been unresponsive hot to touch patient placed on cardiac monitor noted to have slight response to painful stimuli patient IV access established patient fluid bolus given and patient placed on non-rebreather passive oxygenation began and preparations began for airway management facility provides paperwork including DNR patient determined to be appropriate for non-rebreather per [organization] guidelines. Patient reported to have been given 1g of rocephin prior to EMS activation.Vital Signs9:34 a.m. BP 90/palpHR 72SpO2 86% Resp rate 40Effort RapidGlucose 4089:41 a.m. BP 90/palpHR 143SpO2 88%Resp rate 42Effort Rapid9:34 a.m. 15 liters/minute [LPM] nonrebreather mask. Response: unchanged9:36 a.m. 600 ml normal saline. Response: unchanged9:40 a.m. 20 LPM nonrebreather mask. Response: unchangedReview of Resident #1's hospital record dated, [DATE] showed: Chief Complaint BIBA [brought in by ambulance] from [facility name] for AMS [altered mental status]. Pt [patient]was found unresponsive by staff, and EMS [emergency medical services] was called. Sats [oxygen saturation] in the 70s per EMS PTA [patient transport assistant]. Pt arrives responding to painful stimuli, tachy [tachycardia-rapid heart rate], and febrile. Extensive hx [history]History of Present Illness [AGE] year-old male with significant past medical history including epilepsy, prior CVA [cerebrovascular accident], diabetes, hypertension, obesity, prostate carcinoma, atrial fibrillation, HIT [heparin induced thrombocytopenia], and IVC [inferior vena cava filter] filter placement was found unresponsive at [facility name] with oxygen saturations in the 70s. Patient was transported to the emergency department where he was noted to be febrile with a temperature of 107.4, hypoxic, septic, and in respiratory distress, placed on oxy [oxygen] mask at 15 L. Laboratory values revealed influenza A positive, severe hyponatremia, lactic acidosis, trending troponin, and elevated Pro-Cal [procalcitonin, which indicate a systemic inflammatory response to severe bacterial infection or sepsis]. He was transferred to the critical care unit for management for septic shock and multisystem metabolic derangements. Intensive Care Unit (ICU) notedInfectious:-Sepsis bundle initiated in the emergency department patient was given 1 L LR [lactated ringer's] bolus/50 mL NS [normal saline]-After arriving at the critical care unit patient was given 2 L LR bolus- [Infectious Disease Dr] consulted for infectious disease-Cefepime and vancomycin ordered per infectious disease recommendations-Tamiflu-Monitor for temperature curve, temperature 107.4 on arrival to the unit-Cooling blanket system placedThis patient is critically ill with septic shock requiring multiple (continued on next page)

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	105428	A. Building B. Wing	03/12/2026

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	vasopressors and acute hypoxic respiratory failure requiring mechanical ventilation requiring ongoing evaluation and management in the intensive care unit.Assessment:Septic shock requiring vasopressor supportAcute hypoxic respiratory failure requiring mechanical ventilationInfluenza A infectionCommunity-acquired pneumoniaSevere hypernatremiaStress hyperglycemia versus uncontrolled diabetesLactic acidosisHistory of atrial fibrillation not on anticoagulationHistory of epilepsyHistory of prostate cancerIVC filter[DATE]: Overnight patient is steadily declining. Patient is in multiorgan failure. [DATE] 2:50 p.m. Time of death. An interview was conducted on [DATE] at 12:54 p.m. with Resident #1's PCP/Medical Director. He said he talked to staff a few times over the weekend about Resident #1. He said on Saturday [DATE] around 12:00 p.m. the nurse called and he gave orders for STAT labs, STAT chest x-ray and breathing treatments. He said he also ordered Ceftriaxone to be administered for three days. The PCP said he did not become aware until later Resident #1's labs did not get entered as STAT labs and were not completed that day. He was also unaware Resident #1 did not receive Ceftriaxone on Saturday [DATE] when it was ordered or on Sunday [DATE] when it was documented as refused. The PCP said he would have expected the antibiotic to have been administered on Saturday [DATE] when it was ordered. He said he did not know if the delay in Resident #1 getting Ceftriaxone would have fixed the issues because the resident probably already had flu and pneumonia, but it could have made it worse. The PCP said as far as the labs not being ordered STAT; the labs did not show the resident was septic, however, with the critically high sodium level he would have definitely given fluids if I had seen those [lab results] on Saturday. The PCP said, any delay in care is not our policy and not acceptable. The PCP said he reviewed the hospital record and saw they diagnosed the resident with pneumonia and sepsis but the labs and imaging in the facility did not show that. He said the labs drawn on [DATE] had a critically high sodium level but, the white blood cells were normal. He said the chest x-ray done on [DATE] showed atelectasis. He said that is like where the small parts of the lungs collapse. He said it can look kind of like bubbles on the x-ray and can hide pneumonia or be mistaken as pneumonia. An interview was conducted on [DATE] at 10:05 a.m. with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON said Resident #1 started coughing and running a fever on Sunday night shift (11:00 p.m. [DATE] through 7:00 a.m. on [DATE]). She said the nurse notified the doctor and he ordered labs and Flu/COVID/RSV panels. The DON said Flu/COVID/RSV panels are ordered when a resident's temperature is over 99.0 Fahrenheit (F). She said she saw Resident #1 when she came in to work the morning on [DATE] and he did not look that bad and his oxygen saturation was fine. She said one CNA was giving him water and another was going to try to feed him. The DON said she got a message from Resident #1's RR that said they wanted him sent to the hospital. The DON said on Saturday [DATE] Resident #1 should have been given Ceftriaxone when it was ordered. She said the nurse tried to give a dose on Sunday [DATE], but the resident refused. The DON said the doctor and RR should have been called when the resident refused the Ceftriaxone on [DATE]. The DON reviewed Resident #1's medical records and confirmed there was no documentation there was notification of the medication refusal to the provider or family. The DON said upon review she found the labs ordered on Saturday for Resident #1; were entered as routine labs, not STAT labs. She said routine labs are not drawn on Sunday morning which would have put them scheduled for Monday morning, [DATE]. The DON confirmed STAT labs can be drawn any day and time. She said the lab usually comes within a couple of hours and has results back in about four hours. The DON read a statement from Staff H, LPN/Weekend Supervisor regarding Resident #1 on Saturday [DATE] that said Resident #1 had audible breathing and congestion; the doctor was called and ordered STAT chest x-ray, STAT labs, and nebulizer treatments. A follow-up interview was conducted on [DATE] at 1:27 p.m. with Resident #7 and Resident #1's PCP/Medical Director. The PCP said he expected labs to be completed as ordered and to be notified of results. When discussing lab concerns related to Residents #7 and Resident #1, the Medical Director said, sounds like a problem with the lab process. He added that the facility started doing education already due to the issues found. Review of a facility in-service education titled Change in Condition: Nu

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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 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure laboratory orders were entered properly in the electronic medical record and electronic laboratory (lab) portal, for four (#7, #1, #8, #9) out of six residents sampled.Resident #7's labs were not completed as ordered and Resident #7 suffered a cardiac arrest This failure created a situation that resulted in a worsened condition and the likelihood for serious injury and/or death to residents and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the scope and severity was reduced to a D after verification of removal of immediate jeopardy. Cross Reference F684.Findings included: 1.Review of admission Record showed Resident #7 was admitted on [DATE] with diagnoses including unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, gastro-esophageal reflux disease without esophagitis, essential (primary) hypertension, and generalized anxiety disorder. Review of Resident #7's Quarterly Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) could not be conducted due to the resident rarely/never being understood. Review of Resident #7's Care plan showed a focus area of risk for cardiovascular complications related to (r/t) hypertension, dated [DATE]. Interventions included monitor for shortness of breath (SOB), chest pain, bradycardia, hypotension, tachycardia, hypertension, increased edema, weight gain, etc. report any significant abnormalities to the medical doctor. Review of Resident #7's physician orders showed: -STAT (immediate) Complete blood count (CBC) (a common blood test that measures red/white blood cells, hemoglobin, hematocrit, and platelets to evaluate overall health, diagnose symptoms and detect infections) and comprehensive metabolic panel (CMP) (a blood test that measures key indicators of kidney and liver health, electrolytes, blood sugar, and protein levels). Dated [DATE] at 11:13 a.m.Review of Resident #7's progress notes showed: -[DATE] 12:00 p.m. Narrative Note (General) Late Entry: Created [DATE] 3:03 p.m. by Staff K, LPNResident is showing signs of shortness of breath, slightly labor [sic] breathing, oxygen reading at seventy three on room air. MD [Medical Doctor] notified ordered oxygen at two liters, stat chest x ray, stat cmp, neb [nebulizer] tx [treatment] and cbc and UA/CS [urinalysis/culture and sensitivity]. Guardian called voicemail left. Resident is in bed at this time with oxygen at 2L. The resident has to be redirected to keep nasal cannula in place. Bed is in the lowest position and call light is within reach.An interview was conducted on [DATE] at 2:36 p.m. with Staff K, LPN. Staff K said she took care of Resident #7 during the 7:00 a.m. to 3:00 p.m. shift on [DATE]. Staff K said PCP's Advanced Registered Nurse Practitioner (ARNP) came in and ordered STAT labs and x-ray. Staff K said STAT labs had to be put into a lab website and Staff P, Registered Nurse RN/Unit Manager (UM) put the labs in the site for her. Review of Resident #7's medical records did not show any lab results from [DATE]. An interview was conducted on [DATE] at 1:00 p.m. with the laboratory company for the facility. The lab looked up Resident #7's record and said they did not show a phone call or requisition ticket entered for STAT labs on [DATE]. They said no labs were drawn for Resident #7 on [DATE]. The lab representative said if STAT labs are ordered the nurse had to go to their website and create a ticket with the lab requisition and mark that they were ordered STAT. They said the ticket being created triggered the STAT lab process. The lab said STAT labs are drawn between 75-90 minutes after the ticket is created and resulted within four hours. Review of Resident #7's progress notes showed: [DATE] 12:41 a.m. Narrative Note (General) by Staff I, LPN This writer was just on coming for night shift and performing walking round. oncoming CNA called for a nurse to [Resident #7's room]. Upon arrival to the room, the resident was observed laying on her bed. she was very pale and had gasping breaths. This writer obtained vitals BP [blood pressure] 96/60, p [pulse] 58, RR [respiratory rate] 4-6 bpm, O2 sat 73% on O2@2l. The resident's eyes then closed and respirations (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ceased. This writer performed sternal rub with no response from resident. lost pulse and O2 sat. Sent a CNA to check code status. Was advised resident is full code. This writer called code blue at [11:09 p.m.]. this writer initiated chest compressions and CPR at [11:10 p.m.]. this writer delegated code notes to CNA. Other staff arrived. Another nurse called 911 at [11:11 p.m.]. other staff arrived to assist this writer and cna [sic] with break from CPR. [11:18 p.m.] CPR paused to check for vitals resident had no pulse and no respirations. CPR resumed and continued with the dispatcher on the phone guiding until EMS arrived at [11:20 p.m.]. 2 nurses and 3 CNA performed CPR in Rotations until EMS came and took over the code. Resident transferred to stretcher and taken to [Hospital] on stretcher and with EMS via ambulance at [11:33 p.m.]. Call placed to resident guardian and message left of resident transfer to hospital at [11:46 p.m.]. MD notified of code blue and transfer to [Hospital] at [11:51 p.m.].An interview was conducted on [DATE] 1:27 p.m. with the PCP/Medical Director. He was unaware the STAT labs were not completed for Resident #7 and said they should have been.An interview was conducted on [DATE] at 3:10 p.m. with the PCP/Medical Director's ARNP. The ARNP said she ordered the STAT labs for Resident #7 on [DATE], but she was not aware the resident's STAT labs were not completed as ordered. The ARNP said her expectation is for orders to be completed and the nurse to call with results when they come in.An interview was conducted on [DATE] at 2:07 p.m. with the Director of Nursing. (DON). The DON said for the lab process the nurse should put orders in the computer, then go to the lab portal and enter the orders in the chat box for STAT orders. She said it is a new process to the nurses, and they don't seem to be doing it right. She said as soon as the labs are back the nurse should notify the provider and document the notification in the medical record. The DON reviewed Resident #7's record and confirmed there was no lab results on [DATE]. 2.Review of admission Records showed Resident #1 was admitted on [DATE] with diagnoses including aphasia, apraxia, hemiplegia/hemiparesis affecting right side from cerebrovascular disease, and dementia. Review of Resident #1's Quarterly MDS dated [DATE], Section C, Cognitive Patterns, showed a BIMS couldn't be conducted due to the resident being rarely/never understood. Review of Resident #1's medical records revealed a Determination of Incapacity signed by a physician, dated [DATE]. Review of Resident #1's orders showed: -CBC and CMP Every night shift for labs for 1 day. Start date [DATE]. -Flu swab, COVID swab, RSV swab, CBC, CMP one time only for SOB, respiratory. Start dated [DATE]. Review of Resident #1's progress notes showed: -[DATE] 1:57 a.m. Resident presented with fever of 101.2 and SOB with labored breathing MD notified new orders received to obtain labs, flu, covid [sic], rsv [sic] [respiratory syncytial virus-a virus that affects the lungs] testing, start levsin, repeat chest x-ray and duo neb [Ipratropium bromide/albuterol sulfate nebulizer] prn [as needed] Tylenol prn HOB [head of bed] elevated at 90 digress [sic]. POA [power of attorney] made aware of situation.-[DATE] 4:38 a.m. Change In Condition: Fever, shortness of breath. BP 113/64, pulse 109, respirations 24, temperature 101.2, O2 sats 89%, blood glucose 367. Respiratory status evaluation: shortness of breath, labored or rapid breathing. Cardiovascular status evaluation: new irregular pulse. Review of Resident #1's lab results showed a CBC, CMP, flu and COVID test was collected on [DATE] at 5:52 a.m. Results showed: -Hemoglobin (Hg) high at 18.6 with a reference (ref) range of 13.8-17.2-Hematocrit (Hct) high at 58.6 with a ref range of 41.0-50.0-Platelet count low at 91 with a ref range of 130-400-Glucose Serum high at 304 with a ref range of 70-105-BUN (blood urea nitrogen) high at 49 with a ref range of 7-25-Creatinine Serum high at 2.33 with a ref range of 0.70-1.30-Sodium Serum CRITICALLY HIGH at 164 with a ref range of 135-145-Flu A positiveAn interview was conducted on [DATE] at 2:30 p.m. with Staff D, LPN. She said she cared for Resident #1 on Saturday [DATE] during the day shift. She said the resident did not look like himself, was not vocal like normal, and had a temperature over 102. Staff D said she contacted Resident #1's PCP/Medical Director on [DATE] at 11:28 a.m. when the resident's fever was 102, his O2 saturation was 89%, and he had crackles in lung sounds. Staff D said the PCP gave orders for oxygen, nebulizer treatments, Ceftriaxone antibiotic injections for 3 days, flu and COVID swabs, STAT chest x-ray, STAT CMP, and STAT CBC. Staff D was observed reading the (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	text messages from her phone. Staff D said at first when Staff H, LPN/Weekend supervisor looked at the texted orders she thought maybe the PCP meant only the chest x-ray was STAT, but Staff D said she told her they were all STAT and Staff H, LPN/Weekend Supervisor put the orders in the computer to help out. Staff D said she was new in the facility and did not know who did the flu and COVID swabs or if the lab did those. Staff D said she thought maybe she should have sent Resident #1 out to the hospital on Saturday [DATE] but his oxygen saturation showed improvement when he was put on oxygen. Review of Resident #1's physician orders did not show any orders for flu and COVID swabs on [DATE]. The resident's medical records did not show any progress notes or documentation of Resident #1's change in condition on [DATE]. An interview was conducted on [DATE] at 12:01 p.m. with Staff H, LPN/Weekend Supervisor. Staff H confirmed she worked on Saturday [DATE] day shift. She said she entered STAT orders for chest x-ray, labs, Ceftriaxone, nebulizer treatment, and oxygen at 2 p.m. for Resident #1. She said she did not recall if the labs were done.Review of Resident #1's physician orders showed a CBC and CMP order was placed on [DATE] at 12:32 p.m. by Staff H, LPN/Weekend Supervisor. The order was placed for routine labs to be completed on [DATE]. The orders did not show a flu or COVID test was ordered until Monday [DATE]. An interview was conducted on [DATE] at 3:01 p.m. with Staff G, LPN. Staff G said she worked from Sunday [DATE] 11:00 p.m. until Monday [DATE] at 7:00 a.m. She said around 11:30 p.m. Resident #1 had more congestion and was warm to touch. She said he was already on oxygen, so she texted the resident's PCP. She said the doctor explained what he had already done and ordered a repeat STAT chest x-ray. Staff G said the resident had a temperature of 101.2 but it went down after getting Acetaminophen. She said Monday morning Resident #1 was moaning and breathing harder. She said she had given report to the oncoming nurse and then she stayed to help get the resident sent out to the hospital. Review of Resident #1's hospital record dated, [DATE] showed: Chief Complaint BIBA [brought in by ambulance] from [facility name] for AMS [altered mental status]. Pt [patient]was found unresponsive by staff, and EMS [emergency medical services] was called. Sats [oxygen saturation] in the 70s per EMS PTA [patient transport assistant]. Pt arrives responding to painful stimuli, tachy [tachycardia-rapid heart rate], and febrile. Extensive hx [history]History of Present Illness [AGE] year-old male with significant past medical history including epilepsy, prior CVA [cerebrovascular accident], diabetes, hypertension, obesity, prostate carcinoma, atrial fibrillation, HIT [heparin induced thrombocytopenia], and IVC [inferior vena cava filter] filter placement was found unresponsive at [facility name] with oxygen saturations in the 70s. Patient was transported to the emergency department where he was noted to be febrile with a temperature of 107.4, hypoxic, septic, and in respiratory distress, placed on oxy [oxygen] mask at 15 L. Laboratory values revealed influenza A positive, severe hyponatremia, lactic acidosis, trending troponin, and elevated Pro-Cal [procalcitonin, which indicate a systemic inflammatory response to severe bacterial infection or sepsis]. He was transferred to the critical care unit for management for septic shock and multisystem metabolic derangements. [DATE]: Overnight patient is steadily declining. Patient is in multiorgan failure. [DATE] 2:50 p.m. Time of death. An interview was conducted on [DATE] at 12:54 p.m. with Resident #1's PCP/Medical Director. He said he talked to staff a few times over the weekend about Resident #1. He said on Saturday [DATE] around 12:00 p.m. the nurse called and he gave orders for STAT labs, STAT chest x-ray and breathing treatments. He said he also ordered Ceftriaxone to be administered for three days. The PCP said he did not become aware until later Resident #1's labs did not get entered as STAT labs and were not completed that day. The PCP said as far as the labs not being ordered STAT; the labs did not show the resident was septic, however, with the critically high sodium level he would have definitely given fluids if I had seen those [lab results] on Saturday. The PCP said, any delay in care is not our policy and not acceptable. The PCP said he reviewed the hospital record and saw they diagnosed the resident with pneumonia and sepsis but the labs and imaging in the facility did not show that. He said the labs drawn on [DATE] had a critically high sodium level but, the white blood cells were normal.An interview was conducted on [DATE] at 10:05 a.m. with the (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing Home Administrator (NHA) and the Director of Nursing (DON). The DON said Resident #1 started coughing and running a fever on Sunday night shift (11:00 p.m. [DATE] through 7:00 a.m. on [DATE]). She said the nurse notified the doctor and he ordered labs and Flu/COVID/RSV panels. The DON said Flu/COVID/RSV panels are ordered when a resident's temperature is over 99.0 Fahrenheit (F). She said she saw Resident #1 when she came in to work the morning on [DATE] and he did not look that bad and his oxygen saturation was fine. She said one CNA was giving him water and another was going to try to feed him. The DON said she got a message from Resident #1's RR that said they wanted him sent to the hospital. The DON said upon review she found the labs ordered on Saturday for Resident #1; were entered as routine labs, not STAT labs. She said routine labs are not drawn on Sunday morning which would have put them scheduled for Monday morning, [DATE]. The DON confirmed STAT labs can be drawn any day and time. She said the lab usually comes within a couple of hours and has results back in about four hours. The DON read a statement from Staff H, LPN/Weekend Supervisor regarding Resident #1 on Saturday [DATE] that said Resident #1 had audible breathing and congestion; the doctor was called and ordered STAT chest x-ray, STAT labs, and nebulizer treatments. A follow-up interview was conducted on [DATE] at 1:27 p.m. with Resident #7 and Resident #1's PCP/Medical Director. The PCP said he expected labs to be completed as ordered and to be notified of results. When discussing lab concerns related to Residents #7 and Resident #1, the Medical Director said, sounds like a problem with the lab process. He added that the facility started doing education already due to the issues found. 3. Review of admission Records showed Resident #8 was admitted on [DATE] with diagnoses including Type II Diabetes Mellitus, obesity, hypotension, anxiety disorder, gastrostomy status, muscle weakness, cognitive communication deficit. Review of Resident #8's Quarterly MDS, dated [DATE], Section C, Cognitive Patterns, showed a BIMS score of 15, indicating she was cognitively intact. Review of Resident #8's progress notes showed: [DATE]- Got report from night shift that resident was a bit more confused than normal, notified provider that resident was vomiting and not eating meals, provider ordered STAT labs for CBC, CMP & ammonia level. prior UA [urinalysis] was already collected on night shift early Saturday Morning [DATE]. Shortly after heard resident on a call with 911 dispatch saying she was trying to get out of restaurant bathroom, and she needed someone to come help her leave the restaurant. Got on phone with dispatch to ensure them that resident wasn't at a restaurant she was at Nursing home facility. Dispatch verbalized understanding. Notified provider again. Provider ordered Rocephin 1gm IM [intramuscular] for five days daily. first dose given on [DATE]. Resident was assisted out of bed to wheelchair, fluid encouraged, vital signs taken 126/79, 110p [pulse], 97.7 T [temperature], 16 resp [respirations], 96o2 [oxygen saturation]. will continue to monitor resident. Will pass on to next nurseReview of Resident #8's physician orders showed:-STAT labs. CBC, CMP, ammonia level for nausea and vomiting and confusion. Start [DATE] at 8:56 a.m. Review of Resident #8's lab results showed the labs were collected on [DATE] at 10:00 a.m. There were results for the CBC and CMP, however, there were no ammonia level results. An interview was conducted on [DATE] at 4:51 p.m. with Staff Q, LPN. Staff Q said she cared for Resident #8 on [DATE] and received orders from the doctor for her labs, however, Staff R, LPN put the lab orders in for her. An interview was conducted on [DATE] at 5:16 p.m. with Staff R, LPN. Staff R reviewed Resident #8's medical record. She confirmed she put STAT lab orders in the facility's charting system for Resident #8 to help Staff Q, LPN. Staff R said she did not enter STAT orders into the lab system because she thought Staff Q did that. Staff R said the labs were drawn quickly because the lab technician was in the facility drawing labs on another resident, so she stopped them and asked them to draw labs for Resident #8. Staff R said she filled out the lab requisition paper for a CBC, CMP, and ammonia level. Staff R checked Resident #8's lab results and confirmed there were no results for an ammonia level. She said she would call and follow up with the lab to see what happened. An interview was conducted on [DATE] at 9:00 a.m. and at 3:46 p.m. with the lab used by the facility. The lab said there was an incident with Resident #8's ammonia level and the lab was not completed. They said they updated the (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	03/12/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility portal for the resident on [DATE] at 8:12 p.m. with that information. The lab said Resident #8's CBC was reported to the facility portal on [DATE] at 2:04 p.m. and the CMP was reported on [DATE] at 5:20 p.m. The lab said Resident #8's orders for CBC, CMP and ammonia were not put in as STAT orders, only routine. The lab said if the orders had been STAT they would have reported the results sooner and would have called to notify the facility the ammonia lab was not completed. 4.Review of admission Records showed Resident #9 was admitted on [DATE] with diagnoses including atherosclerotic heart disease, neurocognitive disorder with Lewy bodies, essential hypertension, atrioventricular block, first degree, dementia, and cardiomegaly. Review of Resident #9's progress notes showed: [DATE] 7:52 p.m.- Resident observed with episode of vomiting and c/o [complaints of] chest pain. Vitals were taken, blood pressure was elevated. NP [nurse practitioner] notified us of the findings and orders were given. IM promethazine 25MG, clonidine 0.1MG, nitroglycerin 0.4, STAT c/xray 2 views, CBC, and CMP. Will continue to monitor for any further changes.Review of Resident #9's physician orders showed: [DATE] 4:40 p.m. STAT CBC, CMP, chest x-ray 2 views. Portable due to weakness. Review of Resident #9's lab and imaging results showed the chest x-ray was completed on [DATE] at 8:05 p.m. The CBC and CMP were not drawn until [DATE] at 8:15 a.m. and reported [DATE] at 3:26 p.m. An interview was conducted on [DATE] at 3:46 p.m. with the facility's lab. The lab reviewed records for Resident #9 and said a CBC and CMP were ordered routine on [DATE] and they were drawn on [DATE]. The lab said the orders were not put in as STAT orders and that is why they were not drawn until the next morning. The lab said Resident #9's CBC was reported on [DATE] at 2:51 p.m. and the CMP was reported on 2/2126 at 3:18 p.m. An interview was conducted on [DATE] at approximately 11:45 a.m. with the DON and PCP/Medical Director. The DON said she did not know what happened with Resident #9's labs and why they were not done timely. She said the time between ordering and being completed was not acceptable for STAT labs. The PCP said they had put a plan in place for following up on STAT labs because labs had been ordered for residents that had not been completed by nursing.Review of a facility in-service education titled Nursing In-Service: Read-Back Orders & STAT Lab Ordering, undated, showed PurposeTo ensure safe, accurate, and timely implementation of provider orders by reinforcing proper read-back order procedures and STAT lab ordering processes in the skilled nursing facility.Why This MattersFailure to properly read back and implement provider orders can lead to medication errors, delayed treatment, hospitalization, or resident harm. Proper documentation and timely action are required to meet professional standards and CMS expectations.Review of a facility policy titled Provision of Physician Ordered Services, revised [DATE], showed: Policy: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality.Definition:Professional Standards of Quality means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting.Policy Explanation and Compliance Guidelines:1. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. No diagnostic tests or consultation requests will be performed without specific physician, physician assistant, nurse practitioner or clinical nurse specialist's orders in accordance with State law, including scope of practice laws.2. Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity.3. Qualified nursing personnel will receive and review the diagnostic test reports or consults and communicate the results to the ordering Physician, physician assistant, nurse practitioner or clinical nurse specialist within 24 hours of receipt unless the reports fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Ordering Provider will be notified of results upon receipt if deemed critical and/or require immediate attention.4. Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record.The facility's immediate actions to (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	correct the deficient practice and remove the Immediate Jeopardy included: As of 2-17-2026 Resident #7 no longer resides in the facility. She was noted with absence of VS's; a code blue was called and CPR initiated per physician orders. 911 was notified, arrived at the facility and took over CPR. Resident #7 was transported to a local hospital where she expired. Resident #1 no longer resides at the facility. Resident #1 was transferred to the hospital on [DATE] due to respiratory distress and elevated temperature, he expired in the hospital. Resident # 9 no longer resides at the facility. Her labs ordered on [DATE] as STAT were completed on [DATE], STAT CXR was completed on 2-20-26 they were reviewed by the APRN in the electronic medical record on [DATE], no new orders were obtained. Resident #8's STAT labs ordered on [DATE] at 8:56 am were obtained on [DATE] at 10:00 am and resulted on [DATE] the NH3 [ammonia] level ordered did not result due to poor specimen. The provider was notified on [DATE] with no new orders and to discontinue the order for the NH3 level. On 3-10-25 the Director of Nursing was educated by the Regional Nurse Consultant on the process to review clinical records to validate diagnostic testing was completed per health care providers orders and they were notified of the results. On 3-10-26 The Director of Nurses reviewed clinical records of current residents with orders for diagnostic tests from the 30 days to validate labs and or diagnostic tests were completed as ordered. The provider was notified of any discrepancies. On 2-17-26 the Assistant Director of Nursing/Staff Development coordinator began educating licensed nurses on process to obtain STAT labs from current lab services. On 3-11-26 the ADON/SDC educated licensed nurses on process to obtain STAT labs from current lab services. On 3-11-26 the Staff Development Coordinator began lab process competency with license nurses on the process for obtaining routine and STAT labs. On 3-11-26 step by step instructions on how to obtain labs through the website to include STATs was placed in the front of each lab binder. -Total Licensed Nurses -Total licensed nurses received education; 32 of 34 nurses were educated.-On 3-11-26; 32 out of 34 nurses completed the education.-Ad Hoc QAPI on 3-10-26 completed with Medical Director, Administrator, Director of Nursing and additional IDT members on the adherence to policy and process for identifying change in condition, following provider orders, obtaining STAT labs, diagnostic results and notification of providers of lab and diagnostic results. Discussion also included provider access to the electronic medical record and ability to view lab and diagnostic results. Verification of the facility's removal plan was conducted by the survey team on [DATE]. All education and sign-in sheets were reviewed and validated 32 out of 34 licensed nurses educated on the lab process, provider notification and documentation. Interviews to verify education were conducted with 13 out of 34 nurses across all shifts and attempts were made to reach 4 additional nurses. In-Service sign-in sheets were reviewed as well as reports for voice/text education that went out to all licensed nurses. Based on verification of the facility's Immediate Jeopardy Removal Plan the Immediate Jeopardy was determined to be removed on [DATE], and the non-compliance was reduced to a scope and severity of E.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation and interview, the facility did not safeguard medical record information against unauthorized use and ensure residents' personal and medical records were communicated confidentially for one (Resident #1) out of four residents reviewed. Findings include:An observation and interview were conducted on 2/24/26 at 12:54 p.m. with the facility's Medical Director. The Medical Director said staff sent text messages to him about residents regularly. Text messages on his phone were observed with Resident #1's information, including a photo and video of Resident #1.An observation and interview were conducted on 2/24/26 at 2:30 p.m. with Staff D, Licensed Practical Nurse (LPN.) Staff D, LPN showed how she used her personal phone to contact the Medical Director through a Short Messaging Service (SMS) text application. Text messages to and from the Medical Director regarding Resident #1's health status and orders were observed on her phone. Staff D, LPN stated staff used their personal phones to take pictures of prescriptions and texted the pictures to the Medical Director to get an order.An interview with Staff A, LPN was conducted on 2/24/26 at 3:04 p.m. Staff A, LPN revealed she used her personal phone to call and send text messages to physicians. She said she had used her personal phone and regular text messaging system to text pictures of lab results and prescriptions. She stated she did not use a special, secure, system when communicating with providers.An interview with Staff B, Registered Nurse (RN) was conducted on 2/24/26 at 3:11 p.m. Staff B, RN revealed she used her personal phone to call and send text messages to physicians. She stated she had sent text messages containing patient information, pictures of lab results, and pictures of prescriptions. She stated her phone did not have any special or secure text messaging system.An interview with Staff C, LPN, was conducted on 2/24/26 at 3:16 p.m. Staff C revealed she was in training, but if she needed to communicate with the physicians, she would call them using the phone located in the nurses' station. She stated if she needed to send labs or prescriptions, she would have used the fax machine. She stated she would not use her personal phone to communicate with physicians since the message would contain private patient information.An interview with the Director of Nursing (DON) was conducted on 2/24/26 at 3:35 p.m. The DON stated staff should have used the phone in the nurses' station to communicate with physicians. She said personal phone devices should not have been used to communicate with medical staff regarding patient information. The DON said staff should not have texted physicians if they could not get in contact by phone. She stated staff should have reached out to her and she would have reached out to the physician personally.A review of the facility's policy titled Medical Records revealed.6. The facility will safe guard clinical record information against loss, destruction or unauthorized use.A review of the facility's policy titled Resident Right- Personal Privacy/ Confidentiality of Records revealed 1. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.4. The resident has a right to secure and confidential personal and medical records.