

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2026
NAME OF PROVIDER OR SUPPLIER Lake Mariam Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to refund two (Residents #3 and #9) of three sampled residents within thirty days after discharge. Findings included: An interview was conducted with Resident #3's representative (RR) on 04/29/2026 at 9:22 a.m. RR stated not receiving Resident #3's refund from the facility. Review of Resident #3's medical record showed Resident #3 was discharged on 08/10/2025 at 5:55 p.m. to a hospital and passed away on 09/01/2025. Resident #3 was admitted to the facility on [DATE]. Review of Resident #3's financial files transaction report, dated May 1, 2025 to March 31, 2026 showed a total due from patient liability a credit of \$620.29. Meaning the Resident #3 was due a refund from moneys paid. Review of Resident #9's medical record showed Resident #9 admitted to the facility on [DATE] and passed away on 08/20/2026 at 12:20 p.m. Review of Resident #9's financial file transaction report, dated July 1, 2025 to March 31, 2026 showed a total due from patient liability a credit of \$804.81. Meaning the Resident #9 was due a refund from moneys paid. During an interview on 04/29/2026 at 12:11 p.m. with the Business Office Manager (BOM) and Nursing Home Administrator (NHA) the BOM stated that Resident #9 requested a refund. Resident #9's request was sent to the accounts payable office in their corporate office on 3/30/2026, for the amount of \$804.80. The BOM confirmed the refund has not been sent to the resident. The BOM and NHA stated that Resident #3 refund has not been issued. The NHA stated that Resident #9 and Resident #3 have not been issued a refund and both residents have exceeded 30 days post discharge. A review of the facility's Refund of Overpayments Policy not dated revealed: -Purpose: To ensure refund of overpayments are made consistent with applicable legal requirements and standards of practice. -Policy: Personnel will promptly refund to any private payor any overpayment received. Any monies on deposit with the facility shall be refunded upon the appropriate request or the death of the resident. -Procedure: . 3. As soon as it is determined that the overpayment exists, a refund to the appropriate payor should be completed as soon as possible but not later than 60 days. 4. If an electronic adjustment can be completed, it should be completed as soon as possible but not later than 30 days. Refunds Due Residents . within thirty days of the death of a resident, the personal funds . will be made available to the resident's representative. 8. As soon as it is determined that the overpayment exists, a refund to the appropriate payor should be completed as soon as possible but not later than 60 days.</p>		

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

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