STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105455	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Placid Health and Rehabilitation Center	125 Tomoka Blvd S Lake Placid, FL 33852

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to identify and assess a change in condition in a timely manner for one resident (#1) of three residents sampled.Findings Included: Review of Resident #1's admission record revealed an initial admission date of 07/01/2019 and a discharge date of 07/28/2025. Resident #1 was admitted to the facility with diagnosis to include multiple sclerosis (07/01/2019), adult failure to thrive (07/01/2019), personal history of urinary (tract) infections (07/01/2019), cystic disease of liver (11/10/2021), dysphagia, oropharyngeal phase (01/17/2024), and abnormal weight loss (12/06/2023). The review showed resident #1 had a responsible Party (RP) who was also the POA (Power of Attorney) and Emergency contact #1. Review of Resident #1's annual Minimum Data Set (MDS) dated [DATE] revealed in Section C - Cognitive Patterns, a brief interview mental status (BIMS) score of 07 out of 15 meaning, severe cognitive impairment. Review of Section GG - Functional Capabilities revealed for toileting hygiene Resident #1 required substantial/maximal assistance, where helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Review of Section H. Bladder and Bowel revealed Resident #1 was always incontinent for bladder and bowel. Review of Resident #1's assessments - eINTERACT Transfer Form dated 07/28/2025 at 3:30 p.m. revealed Resident #1 was sent to the hospital. Reason for Transfer: Altered Mental Status. Mental and Mobility Status: Alert, oriented, follows instructions, not ambulatory. During an interview on 09/24/2025 at 10:51 a.m., Staff A, Certified Nursing Assistant (CNA) stated she started noticing Resident #1 not eating as much on Saturday (07/26/2025). She stated Resident #1 always liked to eat yogurt and cereal for breakfast but that Saturday she could barely get her to eat the yogurt. Staff A stated she had to convince Resident #1 to try to take a few bites of a peanut butter and jelly sandwich during lunch meal. Staff A said, I worked with Resident #1 next on Monday (07/28/2025). This day she was assigned to me for her bath. Resident #1 normally complains on her shower days. But this day she was not herself, she let me wash her hair and give her a complete bath with no complaints. Staff A stated, That was not like [Resident #1]. She was not herself that day. I know Resident #1, and she was not her normal self. I went and told the nurse in the morning that Resident #1 was not herself and she told me I know, I know. Staff A stated the nurse did not go check on Resident #1 when notified, and she continued passing her medications. Staff A stated normally Resident #1 was always very wet and needed to be changed often but on Monday (07/28/2025) the resident was dry each time she checked her. Staff A said, I worked until 3 p.m. that day and when I did my walking rounds with the oncoming CNA, I told her Resident #1 had been dry all day. Later that night I spoke with the CNA who told me Resident #1 was sent to the hospital. Review of Resident #1's physician orders active as of 07/28/2025 revealed:On 07/28/2025 - Send to emergency room (ER) for eval and treat. No directions specified for order.On 07/28/2025 - Urinalysis and Culture & Sensitivity (UA C&S), Complete Blood Count (CBC), comprehensive metabolic panel (CMP). Review of Resident #1's medical record revealed there were no documented assessments following a reported change in condition. There were no vitals recorded nor monitoring of temperature, blood pressure, oxygen, or respirations obtained when Staff A, CNA noticed the change on 07/26/2025 through 07/28/2025. Review of a progress note for Resident #1 dated 07/28/2025 at 6:40 p.m., Writer called (hospital) to check status on Resident #1, and ER nurse stated resident would be admitted for septic and dehydration. Review of a nursing progress note for Resident #1 dated 07/28/2025 at12:20 p.m. showed, Spoke with [Resident #1], resident seems more tired than normal, woke and responded appropriately if a little drowsy, resident stated she was not in pain, denied burning during urination, updated family member and who is requesting we call the physician and get urinalysis to check for UTI, notified physician and received orders for UA C&S and CBC, CMP. During an interview on 09/23/2025 at 2:31 p.m., Staff B, Licensed Practical Nurse (LPN) stated she was assigned to Resident #1 on the day she went out to the hospital. Staff B stated, I saw her that morning during medication pass. The only thing she complained about to me was she was really tired. I thought it was because her roommate liked to yell out at night and thought that maybe she didn't get very good sleep the night before. Towards the end of my shift the CNA (Certified Nursing Assistant) came and got me and the unit manager to check on Resident #1. I went in her room and Resident #1 was not responsive. She was septic. She was still breathing but was hot to the touch. I did not do any type of vitals or assessment. I could just tell she was not okay. Staff B stated when a resident leaves for the hospital, I complete a nurse's note, call the physician to get an order, complete the transfer from, notify the family, call