

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105620	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/05/2025
NAME OF PROVIDER OR SUPPLIER Highlands Lake Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4240 Lakeland Highlands Rd Lakeland, FL 33813	

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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure scheduled pain medication was provided as ordered for one resident (#1) out of three residents sampled for pain. Findings included: On 11/04/2025 at 9:06 a.m., an interview was conducted with Resident #1 in his room. Resident #1 was observed adjusting the level of the bed in a more down position and stated he is in a lot of pain. Resident #1 stated, I haven't gotten my pain medication in three days. Resident #1 stated the pain medication he was missing was Oxycontin extended release. Resident #1 stated last night it took over six and a half hours to get his pain medication and then he threw it up. Resident #1 stated his pain is a 10 no, an 11 right now. On 11/04/2025 at 9:15 a.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN) assigned to Resident #1. Staff A, LPN stated she had recently administered Resident #1's Hydrocodone as scheduled but did not realize the resident was missing his Oxycontin for three days. She stated she will contact the ordering provider for a new prescription. On 11/04/2025 at 9:20 a.m., an interview was conducted with Staff B, Licensed Practical Nurse/Unit Manager (LPN/UM). Staff B, LPN/UM stated if a resident was out of a medication, especially a narcotic, the nurse can call the pharmacy to obtain a code to obtain a missing dose in our [electronic medication dispensary] but only if the prescription was still good. If not, the nurse would have to call the ordering doctor to obtain a new order. Staff B, LPN/UM reviewed the order and stated Resident #1 has an order for Oxycontin 15 mg (milligram) extended release (ER) twice a day (bid) and Hydrocodone 10 mg/325 mg as needed (prn). Staff B, LPN/UM reviewed the Medication Administration Record (MAR) for October and November 2025 and stated the resident did not get the Oxycontin medication as ordered and will text the doctor to get a new prescription. Staff B, LPN/UM stated the resident did not get his medication as ordered for the Oxycontin 15 mg ER on 10/31, 11/02, or 11/03. Staff B, LPN/UM was able to explain why the resident received his Oxycontin 15 mg ER medication on 11/01. She stated the pharmacy had dispensed originally 12 tablets out of a possible 14 tablets. The two tablets could be dispensed for the future if needed and the nurse requested the medication on 10/31 in the evening and the two tablets were delivered by the pharmacy to have available for 11/01. A review of Resident #1's admission Record showed an admission date of 8/30/2025 with the following diagnoses: Metabolic Encephalopathy Sepsis Type 2 diabetes mellitus w/ hyperglycemia Chronic diastolic (congestive) heart failure Cellulitis of unspecified part of limb Acute kidney failure with tubular necrosis Cardiomyopathy Difficulty in walking not elsewhere classified Chronic venous hypertension with ulcer of bilateral lower extremities Depression (unspecified_ Varicose veins of bilateral extremities with other complications Lymphedema not elsewhere classified A record review of Resident #1's admission Minimal Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of total of 15, indicating the resident was cognitively intact. In Section J-Health Conditions, Pain Management- complete for all residents, regardless of current pain level, Question A. -Received scheduled pain medication regimen? -No, Question B. - Received PRN pain medications or was offered and declined? Yes, Question C. - Received non-medication interventions for pain? No, Section J0200 Should pain assessment interview be conducted? Yes, Section J0300 Pain Presence: Ask resident: Have you had pain or hurting at any time in the last 5 days?' Yes, Section J0410 Pain Frequency: Ask resident: How much of the time have you experienced pain or hurting over the last 5 days? Almost constantly, Section J0150 Pain Effect on Sleep: Ask resident: Over the past 5 days, how much of the time has pain made it hard for you to sleep at night? Almost constantly, Section J0520 Pain Interference with Therapy Activities: Ask resident: Over the past five days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain? rarely or not at all, Section J0600 Pain Intensity- admission on LY ONE of the following pain intensity questions (A or B), A. Ask resident: Please rate your worst pain over the last five days on a zero to 10 scale, with 0 being no pain and 10 as the worst pain you can imagine (show resident 00-10 pain scale) enter 2- digit response enter 99 if unable to answer. 9.A record review of Resident #1's Care Plan showed the following: -Focus of opiate medications related to: pain not managed by alternative interventions, initiated on 9/09/2025 with a goal statement: resident risk for adverse effects related to use of opioids will be minimized through next review date, initiated on 9/09/2025. Interventions include but are not limited to: administer medication as prescribed by the physician (see current MA Rand physician orders for current dosage) initiated on 9/09/2025.-Focus area of pain and/or is at risk for pain related to decreased mobility PVD (peripheral vascular disease) and neuropathy initiated on 9/02/2025 with a goal</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure the narcotics policy was followed by nursing to ensure narcotic audits were accurate for three residents (#1, #8 and #9) out of three residents sampled for pain management. Findings included: On 11/04/2025 at 8:33 a.m., an interview was conducted with Staff G, Licensed Practical Nurse (LPN). Staff G, LPN stated when narcotics are delivered, Staff G, LPN would sign a yellow sheet of paper and a hand-held device where an electronic signature would be required by the pharmacy. A copy would be provided to the nurse. Staff G, LPN stated he would take the prescription along with the actual narcotic card and place the prescription in the narcotic book located on the medication cart and place the narcotic card inside the locked area of the medication cart for narcotics. The copy of the yellow sheet will go to the unit manager's box. Staff G, LPN stated if a narcotic and/or a resident has been discontinued, the process would be to remove the narcotic card and take the Unit Manager, and both will sign off. The Unit Manager will bring the discontinued narcotic cards to the Director of Nursing (DON). Staff G, LPN stated he has two discontinued narcotic cards in the assigned cart. On 11/04/2025 at 8:40 a.m., an interview was conducted with Staff A. Staff A, LPN stated when pharmacy delivers a narcotic medication, a yellow copy is signed, and a copy would be provided to the nurse. Staff A, LPN stated a signature would be required as well on the pharmacist's phone. Staff A, LPN stated she would get another nurse to witness the narcotic card going into the cart to ensure the count is correct. Staff A, LPN stated pharmacy delivers at different times. Staff A, LPN stated the card count (Controlled Substance Audit Record) requires two nurses' signature at the change of shift but again she may or may not get a second witness during the day if she places a new narcotic card in the locked narcotic box in the medication cart. Staff A, LPN stated discontinued narcotics are brought to the unit manager or DON along with the white prescription sheet, the count would be verified, and the card count sheet would be updated. On 11/04/2025 at 8:58 a.m., an interview was conducted with Staff H, Registered Nurse (RN). Staff H, RN stated pharmacy delivers around 5-6:00 p.m., and 4-5:30 a.m. Staff H, RN stated the nurse will sign the yellow copy, pharmacy will give a copy to the nurse, and the nurse would sign in their phone. Staff H, RN stated she would get a second nurse to witness the narcotic card placed inside the medication cart. Staff H, RN stated if the narcotic is discontinued, she would take the medication out, adjust the log and bring the narcotic to the Unit Manager or the DON. On 11/04/2025 at 2:30 p.m., an interview was conducted with the DON. The DON stated on 10/21/2025 (Tuesday) she was walking the hallways prior to their 9:00 a.m. morning clinical meeting. The DON stated there were no staff present at the nurses' station, including the Unit Manager assigned to the unit and stated she was probably making her morning rounds. The DON stated she saw in the nurses' station a medication monitoring sheet on top of the nurses' work area. The DON stated the medication monitoring sheet was for Resident #1 and the prescription was for his Hydrocodone 10 mg (milligrams)/325 mg with the date of 10/18/2025 signed by Staff I, LPN. The DON stated the medication monitoring sheet showed the documented total number of tablets received at the top but no further tallies were noted on the sheet. The DON stated she went to cart HP1 to see if the actual medication was in the narcotic drawer. The DON stated there was no narcotic card within the locked narcotic box within the medication cart. The DON stated she looked through the entire medication cart just in case it was misplaced. The DON stated she contacted her Assistant Director of Nursing for assistance. The DON stated they looked in other care areas, checked the med rooms, and shred boxes. The DON stated she checked the shred box in front of the Unit Manager's office and found a blister pack with Resident #1's name still on the pack. The DON stated she immediately notified the Nursing Home Administrator (NHA). The DON stated we notified our regionals and started an immediate investigation. The DON stated upon review of Resident #1 Medication Administration Record (MAR) the resident received his as needed pain medication upon request. The DON stated this particular medication is also available in their [electronic medication dispensary] to ensure the resident had the requested medication for pain available. The DON stated the primary physician was notified and the Advanced Registered Nurse Practitioner (ARNP) prescribed another prescription at no cost to the resident. The DON stated all residents in the unit with a Brief Interview for Mental Status (BIMS) of 12 (mildly impaired) or higher were interviewed. The DON stated all the residents denied any issues with receiving their medications. The DON stated she did not ask specifically about narcotics. The DON stated Staff I, LPN, works per diem and sometimes assigned to other areas in the facility. The DON stated she interviewed the</p>		