

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105693	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Charming Lakes Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 2020 W Lake Parker Dr Lakeland, FL 33805	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and interviews, the facility failed to implement an effective infection control program related to 1. Not following local public health recommendations during an investigation of a possible Legionella outbreak. 2. Failed to ensure respiratory equipment was stored in a clean and sanitary manner for two of two observations. 3. Failed to ensure staff, including providers, used appropriate personal protective equipment (PPE) to prevent the transmission of an infectious pathogen for one resident (#5) of two residents sampled for transmission-based precautions. 4. Failed to display signage identifying the type of precautions that should be used for one resident (#3) of two sampled residents. Findings included:</p> <p>1. Review of Resident #1's clinical record showed the resident was admitted on [DATE] from an acute care facility. The record revealed the resident was admitted with diagnoses including but not limited to unspecified organism sepsis, acute and chronic respiratory failure with hypoxia, unspecified pneumonia, and unspecified chronic obstructive pulmonary disease (COPD). The resident was discharged to an acute care facility on 12/2/24 related to low oxygen saturation.</p> <p>During an interview on 8/7/25 at 1:42 a.m. the Executive Director (ED) reported Resident #1 was at this facility for 12 days and urine had tested positive for Legionella after being discharged. The ED stated the resident had been in and out of the hospital at least three times prior to being at this facility. The ED stated the Department of Health (DOH) had informed her of a suspected case (Legionnaires' disease) and had conducted testing. The facility had reviewed the Water Management Plan and had implemented "some" of the recommendations made by the DOH. The ED stated she would have to look back to see what the other recommendations were.</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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview was conducted on 8/7/25 at 1:28 p.m. with the Director of Maintenance (DM). The DM reported having read about Legionella, it was a bacteria in water faucets, shower heads, and could get into the (water) system. The DM reported working at this building for two years and had not done any (Legionella) testing during this time and had not done an assessment for the bacteria (Legionella). The DM stated he doesn't necessarily monitor for Legionella and the reason for draining the water tanks was because at the last facility he was employed at it was done so he continued it. The DM stated every day water temps were taken, a couple rooms on the north side, couple rooms on the south side, a nutrition room and the two restrooms (near the lobby). He stated the temperatures are between 110° Fahrenheit (F) and 111° Fahrenheit and periodically takes temperatures at the mixing valve of 115-116° Fahrenheit and by the time it gets to where it goes it's not that hot. The DM reported the facility had recirculation pumps which kept the water circulating (without areas of stagnation). The DM stated the lines to the showers and faucets were also kept circulating, and the DM doesn't check temperatures in resident rooms. During the interview the ED asked the DM to report further, he stated he let the water run 10-15 minutes and changed all the aerators (in resident rooms). The ED reported quarterly flushing of the building was done, they did it in November or December, in March, and should have had a quarterly in April, May, or June.</p> <p>An observation was conducted on 8/7/25 at 2:00 p.m. with DM of the South side Boiler Room. The room contained two water heaters. The thermometer on the water heater furthest from the entry door showed a reading of 120° Fahrenheit (thermometer maxed at 120° Fahrenheit) and the thermometer closest to the door read 80 degrees. The reading of 80° Fahrenheit was confirmed by the DM who stated it may be due to resident showers. The DM stated the facility received water from the city and "sometimes" he received water information and would look for an example. The example was not provided by the end of the survey.</p> <p>An interview was conducted on 8/7/25 at 2:44 p.m. with the ED. The ED reported Resident #1's AHCA form 3008 came in with a diagnosis of severe sepsis from an unknown source. The ED reported Resident #1 had tested positive (for Legionella) after discharging from the facility and returning to the acute care facility. The ED reported that the Department of Health (DOH) requested the facility complete a Legionella Environmental Assessment Form (LEAF) prior to the department's arrival, which was completed on 3/13/25, and the county DOH visited the facility on 3/17/25. The ED stated the facility did not have any Legionella concerns as Legionella occurs when breathing in a hot mist and the facility did not have any areas of hot mist. She stated the facility did implement a revision of the Water Management Plan (WMP) as the previous one was generic and outdated. The facility had pulled up city and county water information to see what they were adding to the water and utilized the information to implement the new plan, had to personalize it the facility, did not have the background or current information from the city, or proof of where previous management had received the information from. She reported the DOH had recommended the facility have consultants from water experts, remediation testing and install micron biological point-of-use filters on sinks, showers, and faucets. "We didn't go along with all the recommendations" because the facility had tested negative and "we felt it wasn't necessary". The ED stated the risk assessor named on the new WMP was a Maintenance / Life Safety consultant and he helped write the new plan and policy. She believes the new WMP was sent to the DOH the last week of July.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the DOH letter, dated 3/19/25, sent to the ED of this facility referenced &ldquo;Legionnaires&rsquo; disease case associated with facility&rdquo;. The letter was provided as a follow up to an on-site visit and discussions conducted on 3/17/24 during an investigation of a single confirmed case of Legionnaires&rsquo; disease who reported exposure at this facility between 11/20 and 12/2/24. The letter reported &ldquo;investigating to determine possible sources of the illnesses, and to identify if anyone else has become ill from the disease. Legionnaires disease is caused by the Legionella bacteria that exist naturally in the environment. It can also be found and man-made water systems such as hot tubs, spas, cooling towers, hot water tanks, or large plumbing systems.&rdquo; The letter informed the facility of onsite assessment &ldquo;indicated conditions in the premise plumbing that could harbor and breed biofilms and Legionella bacteria&rdquo; and made the following recommendations in addition to recommendations provided onsite:</p> <ol style="list-style-type: none"> 1. Recommended obtaining professional consultation from a qualified water system expert for proper assessment and remediation of your water system. The remediation action plan must be reviewed by the county DOH and results of follow-up monitoring must be provided to the DOH. The letter showed attachments had been included of accepted remediation and maintenance guidelines. 2. Recommend post-remediation testing following a detailed plan that is submitted to the county's DOH along with results from each post remediation sampling event. Post remediation samples should be collected at least 48 hours after the water system or device has been restored to normal operating conditions through at least a six month period post remediation. <ul style="list-style-type: none"> - We recommend a sampling approach described in HICPAC guidance, in which environment samples are collected for culture at two week intervals for three months and if no Legionella is detected in cultures during three months of monitoring at two week intervals, continue to collect monthly for another three months. - a sampling approach may be adjusted over time based on trend data. DoH must be notified of any adjustments two of the established sampling plan. If Legionella is detected in one or more cultures you should: <ul style="list-style-type: none"> - review and modify the water management plan (WMP) - perform additional remediation, if indicated - implement a new six month period for post remediation follow-up sampling 3. Recommend that the facility either install 0.2 micron biological point-of-use filters on any showerheads or sink/tub faucets intended for use until remediation of your premise plumbing has occurred or restrict the use of showers to reduce the risk to guests during this investigation until remediation actions are completed. 4. Recommend that facility notify incoming residents in writing about the ongoing investigation of a case of Legionnaires&rsquo; disease with association to this facility. This provides residents an opportunity to make an informed decision based on their personal assessment of risk. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview was conducted on 8/7/25 at 4:58 p.m. with the ED. The ED reported she believed in March the Activities Director had informed Resident Council that the DOH was testing for Legionella. The ED stated she had not called any families (regarding the Legionella investigation).</p> <p>Review of the current Annual Water Systems Risk Assessment was dated July 2025, 4 months after the facility had received the DOH recommendations. Review of the Water Systems Management Plan, dated July 2025, showed "This plan is targeted at responding to instances where water sample results are positive for the Legionella bacterium or where a patient from a facility has been identified as having Legionellosis."</p> <p>Review of the Administrator (ED) job description showed the "primary purpose of this position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to ensure that the highest degree of quality care can be provided to the residents at all times." The Duties and Responsibilities of the Administrator include, ensure the planning, development, implementation, and monitoring of facility policies and procedures, and develop and implement a facility compliance program that meets state and federal requirements, ensure that a system for maintaining and improving buildings, grounds, and equipment is planned, implemented, and evaluated.</p> <p>2. On 8/7/25 at 9:30 a.m. an observation of room [ROOM NUMBER] showed a blanket folded up under the Packaged Terminal Air Conditioner (PTAC). The resident in the bed next to the unit stated the blanket was due to water being on the floor and had been like that for a couple of months, then stated it was just a guess it could have been like that for four weeks.</p> <p>3. On 8/7/25 at 9:35 a.m. an observation of a yellow organizer (caddy) containing Personal Protective Equipment (PPE) hanging from the door of room [ROOM NUMBER]. The observation showed a Transmission-based precaution sign for Contact Precautions attached to the yellow organizer.</p> <p>On 8/7/25 at 9:39 a.m. Staff C, Licensed Practical Nurse/Unit Manager (LPN/UM) dressed in yellow precaution gown and gloves before entering room [ROOM NUMBER]. The observation revealed a provider enter room [ROOM NUMBER] without PPE's on and stand next to the bed speaking with Resident #5 as Staff C was standing on the opposite side of the bed dressed in PPE. Staff C left the room, after removing PPE, at 9:42 a.m. as the provider continued in the room without PPE's on. Staff C stated if there was a caddy on the door all staff should be wearing PPE and confirmed the provider in the room was not wearing PPE and should have been.</p> <p>Review of Resident #5's physician orders with an order date of 8/6/2025 revealed, "contact isolation precautions for esbl [Extended-spectrum beta-lactamase]/UTI [urinary tract infection]."</p> <p>4. On 8/7/25 at 9:36 a.m. an observation was made of a nasal cannula tubing wrapped around an emergency tank in room [ROOM NUMBER]. The tubing was not stored in a plastic storage bag.</p> <p>On 8/7/25 at 9:37 a.m. an observation was made of nasal cannula tubing lying on the seat of a wheelchair in the 300-hallway diagonally from room [ROOM NUMBER]. On 8/7/25 at 9:46 a.m. Staff D, Certified Nursing Assistant (CNA) observed the cannula tubing lying in the wheelchair. The staff member reported not knowing whose cannula it was, it wasn't the owners of the wheelchair as the owner did not wear oxygen.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview was conducted on 8/7/25 at 4:24 p.m. with the Director of Nursing/Infection Preventionist (DON/IP). The DON stated if a caddy was on the outside of the door, stop and put on PPE before entering the room, the expectation for storing oxygen tubing was to be in a bag, and said a blanket on the floor to catch water was not appropriate. The DON stated she was made aware of the provider being in the isolation room without PPE (Resident #5's room) and the provider had been educated.</p> <p>5. On 8/7/25 at 9:35 a.m. Personal Protective Equipment (PPE) was observed hanging in a yellow organizer on the door of Resident #3's room. There was no sign on the outside of the door indicating what kind of precautions.</p> <p>Review of Resident #3's medical record revealed he was readmitted to the facility on [DATE] with a diagnosis of: sepsis due to Escherichia Coli (E. Coli) and Enterocolitis due to Clostridium Difficile (C-Diff).</p> <p>Review of Resident #3's physician orders included an order dated 7/29/25 for: contact isolation precautions for C-Diff infection.</p> <p>During an interview on 8/7/25 at 4:30 p.m. with the DON who is also the facility Infection Preventionist (IP), stated that a yellow organizer with PPE hanging outside of a door indicates the resident inside is on isolation precautions and PPE should be put on before entering the room. She stated that you should have a sign outside the door indicating what kind of isolation. The DON stated she educated the staff numerous times on isolation, hand washing and infection control and made rounds a couple of times a week to ensure the signs were there. The DON stated she has told staff not to move the signs.</p> <p>Review of the policy & Infection Control Prevention and Control Program, effective 2/21/23, reported "The facility shall establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." The general considerations included but not limited to:</p> <ol style="list-style-type: none"> 1. The Infection Prevention and Control Program, associated programs, and policies and procedures are based on the facility assessment, incorporating accepted national standards and includes any facility or community risk. 2. The plan should be reviewed and updated as necessary, and a minimum of annually. 3. The facility has designated an Infection Preventionist. The Infection Preventionist is responsible for the oversight of the Infection Prevention and Control Program and works in collaboration with the facility Director of Nursing, Administrator, and Medical Director, and Quality Assurance Committee. <p>The Infection Preventionist serves as resource to staff on infectious illness/disease, infection control and prevention practices, and affected facility processes and examples may include but are not limited to:</p> <ul style="list-style-type: none"> - b. Implementation of isolation precautions; <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<ul style="list-style-type: none"> - c. Exposures; - d. Surveillance & facility and community-acquired infection findings; - e. Compliance and Performance monitors; - f. Results of environmental rounds; - g. Relevant changes in infection prevention and control policies and/or guidelines; - h. Infection related investigations; <p>4. The Quality Assurance Committee shall be responsible for overseeing and implementing the recommendation that result from the program.</p> <p>5. All staff are responsible to follow policies, procedures, and expectations related to the program.</p> <p>The procedure portion of the policy included:</p> <p>10. Resident/Family/Visitor Education and Screening:</p> <ul style="list-style-type: none"> - a. Residents, family members, and visitors shall be provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff. - b. Information on various infectious diseases is available from our Infection Preventionist. - c. Isolation signage is used to alert staff, family members, and visitors of transmission based precautions. <p>13. Water Management</p> <ul style="list-style-type: none"> - A water management program has been established as part of the overall infection prevention and control program. - Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems. - The Maintenance Director serves as the leader of the water management program. <p>Review of a Facility Policy titled Isolation & Initiating Transmission Based Precautions with an effective date of 4/1/22 revealed: When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee) shall post the appropriate notice on the room entrance door and on the front so that all personnel should be aware of precautions or be aware that they must first see a nurse to obtain additional information about the situation before entering the room.</p> <p>(Photographic Evidence Obtained)</p>		