STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106120	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scott Lake Health and Rehabilitation Center	800 E County Rd 540a Lakeland, FL 33813

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review the facility did not ensure medications were stored in accordance with current professional standards for 6 of 6 medication carts, 2 of 4 medication storage rooms, and central supply storage.1. An observation on 4/21/2026 at 3:30 P.M. of the 100 Hall Top Medication Cart revealed:In the top drawer was one loose ciprofloxacin pill; the pill did not have a resident name.In the top drawer was a container of cholestyramine powder that expired on 3/30/2026.The bottom drawer of the medication cart contained 11 safety syringes that expired on 2/3/2026.An interview on 4/21/2026 at 3:35 P.M. with Staff M, Registered Nurse (RN) was conducted. Staff M, RN verified the medications in 100 Hall Top Medication Cart were expired and she said the medications should have been removed. Staff M, RN said all nurses are responsible for removing expired medications and cleaning the medication carts.2. An observation on 4/21/2026 at 4:05 P.M. of the 100 Hall Back Medication Cart revealed:In the second drawer was a medication card for olanzapine that expired on 11/29/2025.In the narcotic drawer was a medication card for Hydrocodone (Norco) that expired on 4/18/2026.The bottom drawer of the medication cart contained a bottle of micro kill bleach wipes next to medication packets (cholestyramine powder) without a divider.An interview on 4/21/2026 at 4:08 P.M. with Staff N, Licensed Practical Nurse (LPN) was conducted. Staff N, LPN verified the narcotic in 100 Hall Back Medications Cart were expired and should have been removed from the medication cart. Staff N, LPN placed the expired medication cards back into the medication cart after the interview was concluded.3. An observation on 4/21/2026 at 4:55 P.M. of the 200 Hall Front Half Medication Cart revealed:The bottom drawer of the medication cart contained a bottle of micro kill bleach wipes touching drinking straws and spoons without a divider.An interview on 4/21/2026 at 5:05 P.M. with Staff O, LPN regarding 200 Hall Front Half Medication Cart was conducted. Staff O, LPN stated, I guess it (bleach wipes) should not be in the cart. Staff O, LPN verified the bleach wipes were touching the straws.4. An observation on 4/22/2026 at 12:00 P.M. of the 400 Hall Medication Cart revealed:Blood glucose test strips with no opened date; to be used within 6 months of openingAn opened inhaler (Budesonide and Formoterol Fumarate Dihydrate) and opened nasal spray stored in the same box; neither medication had an opened or expiration dateThe bottom drawer of the medication cart contained a bottle of bleach wipes next to multiple bottles of oral liquid medications without a divider.An opened inhaler (Ellipta) with no opened or expiration date.There was an opened box of artificial tears that did not contain an opened; a blank sticker on the front of the box read to discard 28 days after opening.Two opened inhalers (Symbicort) with no opened or expiration date; to be used within 3 months of openingAn interview on 4/22/2026 at 12:23 P.M. with the Director of Nursing (DON) regarding the 400 Hall Medication Cart was conducted. The DON said there should be a date listed on these blood glucose test strips. The DON said the blood glucose strips expired 90 days after opening or the nurses should have referred to the directions on the bottle. The DON said the inhaler and nasal spray should not be in the same box and need to have an opened and expired date. The DON said the Ellipta inhaler should not have been in the medication cart; it should have had an opened date. The DON said the box of opened artificial tears should have (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	had an opened date.5. An observation on 4/22/2026 at 2:25 P.M. of the 300 Hall Medication Cart revealed:An opened and used inhalation solution with an opened date of 4/24/2026 with no expiration date.In the narcotic drawer was a bottle of Tylenol Three; the label on the bottle was worn and could not identify the resident or the expiration date6. An observation on 4/22/2026 at 2:35 P.M. of the 200 Hall Back Half Medication Cart revealed:A bottle of AZO that expired in 3/2026In the top drawer were four loose capsulesThe bottom drawer contained a bottle of bleach wipes and hand sanitizer wipes stored with transdermal nicotine patches without a divider7. An observation on 4/21/2026 at 3:55 P.M. of the 100 Hall Medication Room revealed:The medication refrigerator contained a box of Arformoterol Tartrate that expired on 3/2026. The box contained 14 foil packets for inhalation.The upper cabinet in the medication room contained a box of Pilot Covid-19 at Home Tests that expired on 4/27/2025.8. An observation on 4/22/2026 at 3:00 P.M. of the 300 Hall Medication Room revealed:An opened box of NovoLog prefilled pens that expired on 2/2/2026; the box contained 2 pensAn opened box of insulin Lispro prefilled pen that expired on 10/24/2025; the box contained 3 pensAn observation on 4/23/2026 at 10:00 A.M. of central supply revealed:4 bottles of Pink-Bismuth expired on 3/2026A box of acetaminophen suppositories expired on 10/2025An interview on 4/23/2026 at 10:07 A.M. with Staff P, Central Supply, was conducted. Staff P, Central Supply said she was responsible for checking the expiration dates and restocking the supplies. Staff P, Central Supply verified the medications were expired and said she must have missed those.An interview on 4/22/2026 at 4:33 P.M. regarding medication storage with the DON was conducted. The DON said the olanzapine was expired. She said the medication should have been discarded. The DON said the nurses are responsible for removing expired and discontinued medications from the medication carts and storage rooms. The DON said the chemical wipes should not have been stored with medications, straws, or spoons. The DON said there should not have been loose medications in the medication carts. The DON said the insulin and covid tests should have been discarded.A review of an undated policy titled, Medication Storage revealed the policy was Medications will be stored in a manner that maintains the Integrity of the product and ensures the safety of the residents and is in accordance with FL Department of Health guidelines. The procedure was nasal products will be stored separately from other medications for internal use. Medications will be stored in an orderly, organized manner in a clean area. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed of.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure call lights were within reach for eight residents (#63, #115, #61, #7, #98, #124, #82, and #95) out of nine residents sampled for call lights.Findings included:1. An observation on 4/20/2026 at 9:45 A.M. of Resident #63 revealed he was lying in bed; the call light was seen on the floor under the head of the bed.An observation on 4/21/2026 at 3:15 P.M. of Resident #63 revealed he was lying in bed; the call light was seen on the floor in the same position.A review of Resident #63's admission Record showed he was admitted to the facility on [DATE] with diagnoses including but not limited to lack of coordination, difficulty in walking, dizziness and giddiness, and muscle weakness. A review of Resident #63's Annual Minimum Data Set (MDS), dated [DATE] revealed he required partial/moderate assistance for toilet hygiene needs and personal hygiene.A review of Resident #63's active care plan showed a Focus of (Resident #63) is at risk for falls . with an intervention including Visual aids to remind him to use call light for assistance.2. An observation and interview on 4/21/2026 at 3:16 P.M. of Resident #115 revealed he was lying in bed; the call light was tangled in the right-side bed rail and dangling out of Resident #115's reach almost touching the floor. Resident #115 was observed trying to reach his call light for over two minutes; Resident #115 could not obtain the call light. Resident #115 said he could not reach his call light stating, he just gave up.A review of Resident #115's admission Record showed he was admitted to the facility on [DATE] with diagnoses including but not limited to lack of coordination, weakness, and muscle wasting and atrophy.A review of Resident #115's Quarterly MDS, dated [DATE] revealed a BIMS score of 14 indicating intact cognition and revealed he was dependent on toilet hygiene needs and partial/moderate assistance for personal hygiene.3. During an observation on 4/20/2026 at 9:13 A.M. Resident #7 stated she had a stroke and needs assistance with movement. Resident #7 stated she can't reach her call light. Resident #7's Call light was observed wrapped around the bed rail and hanging down the side of the rail out of the reach of the resident.4. During an observation and interview on 4/21/2026 at 10:15 A.M. Resident #124's call light was seen stuck under the bed frame with the button facing down. Resident #124 stated if they ever needed assistance, they yelled out for help until a staff member arrived. During a follow up observation on 4/21/2026 at 3:53 P.M. the call light for Resident #124 was still stuck underneath the bed frame.Review of Resident #124's admission Record revealed an initial admission date of 5/16/2024 and a readmission date of 1/26/2026. Resident #124 was admitted to the facility with diagnosis to include but not limited to acute osteomyelitis left ankle and foot, type 2 diabetes mellitus, asthma, epilepsy, muscle weakness, difficulty in walking, depression, cellulitis of left lower limb, and asthma.Review of Resident #124's Quarterly Minimum Data Set (MDS) dated [DATE] showed Resident #124 required substantial/maximal assistance on staff for toileting, shower/bathing, lower body dressing, and walking.Review of Resident 124's active care plan showed a focus of (Resident #124) has an Activities of Daily Living (ADL) self-care performance deficit . with an intervention to encourage her to use bell to call for assistance.5. During an observation and interview on 4/21/2026 at 10:18 A.M. Resident #82's call light was wrapped around the handrail and hanging down low on the side of the bed. Resident #82 said they did not know what that was or what it was used for.During a follow up observation on 4/21/2026 at 3:45 P.M. the call light for Resident #82 was still wrapped around the handrail.Review of Resident #82's admission Record revealed an initial admission date of 8/9/2022 and a readmission date of 7/27/2023. Resident #82 was admitted to the facility with diagnosis to include but not limited to wedge compression fracture of first lumbar vertebra, muscle weakness, difficulty walking, lack of coordination, cognitive communication deficit, muscle wasting and atrophy, and pain in right knee.Review of Resident #82 active care plan showed a focus of (Resident #82) has an ADL self-care deficit . with an intervention of encourage her to use call bell for assistance.6. During an observation and interview on 4/21/2026 at 10:21 A.M., Resident #95 stated the call light (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was always wrapped around the handrails and she does not know what it is used for.Review of Resident #95 admission record revealed an initial admission date of 3/6/2022 and a readmission date of 10/25/2025. Resident #95 was admitted to the facility with diagnosis to include but not limited to supraventricular tachycardia, unsteadiness on feet, weakness, lack of coordination, muscle wasting and atrophy, Alzheimer's disease, pain in knee, and difficulty in walking. Review of Resident 95's's active care plan showed a focus of (Resident #95) has an Activities of Daily Living (ADL) self-care performance deficit . with an intervention to encourage her to use bell to call for assistance.7. On 4/20/2026 at 11:50 A.M., an observation was made of Resident #61 attempting to reach her call-light. Resident #61 was observed reaching out to a call-light that was tangled on the bed rail to the right of the resident. The call-light button was unable to extend from the railing of the bed. The resident attempted to reach the call-light for over a minute, before stopping the attempt. Resident #61 explained not being able to reach the call-light, due to it being tangled up on the bed rail. Resident #61 stated the call-light was out of reach.Record review of Resident #61's admission Record record revealed the resident was admitted to the facility on [DATE]. The medical diagnosis for the resident included: wheezing, disorder of the skin, low back pain, and shortness of breath.Record review of Resident #61's MDS dated [DATE] revealed a BIMS score was between 13 and 15, which indicated cognition was intact. Review of Resident #61's care plan revealed a focus: Resident #61 has an ADL self-care performance deficit related to weakness. Interventions included: she requires (assistance) by 1 staff to turn and reposition in bed.During an interview on 4/22/2026 at 4:50 P.M., Staff D, Certified Nursing Assistant (CNA), stated a call-light should absolutely not be wrapped around a bed railing.During an interview on 4/22/2026 at 5:03 P.M., Staff E, CNA, stated call-lights should be within reach of the resident.During an interview on 4/22/2026 at 4:58 P.M., Staff A, Licensed Practical Nurse (LPN), stated a call-light should be about a foot and a half from the bed railing, when wrapped around it. Staff A stated if there was not enough length, a resident could have difficulty reaching the call-light. Staff A stated residents should be able to use a call-light immediately. Staff A stated there could be medical risk if a resident was unable to reach a call-light.During an interview on 4/22/2026 at 5:34 P.M., Staff C RN, Unit Manager, stated call-lights should be within reach of residents. Staff C stated that's not acceptable for a resident to struggle with a call-light for two minutes. Staff C stated, the risk to the resident is to not be able to reach us when they need us.8. During an observation on 4/21/26 at 10:00 A.M. Resident #98's call light was wrapped around the handrail, and lodged between the mattress and handrail.Review of Resident #98 admission revealed an admission date of 09/12/2025. Resident #98 was admitted to the facility on [DATE] with diagnosis to include but not limited to senile degeneration of brain, type 2 diabetes mellitus, depression, urinary incontinence, brief psychotic disorder, heart failure, and dementia.Review of Resident #98's Minimum Data Set (MDS) dated [DATE] showed Resident #98 was dependent meaning they relied on staff for self-care and mobility. During an interview on 4/22/2026 at 9:06 A.M. Staff J, Certified Nursing Assistant (CNA) stated residents used their call lights for assistance, or staff members would check in on residents frequently. The call light should be placed near the residents at all times and they are not supposed to be wrapped around the handrail, under the bed, or stuck under the bed frame.During an interview on 4/22/2026 at 9:26 A.M. Staff K, CNA stated residents were to use call lights, which should be located on the bed, if they required assistance. Sometimes call lights could be wrapped around the handrail due to preference, while others preferred it on their stomach or bed. Staff K stated the call lights were not easily accessible for Resident #82, #95, and #124.During an interview on 4/22/2026 at 12:29 P.M. Staff C Registered Nurse (RN) and Unit Manager (UM) stated call lights were to be within reach which means it can be clipped somewhere close to the residents. Staff C stated call lights were not supposed to be wrapped around the handrails but it depended on resident preferences. Staff C stated call lights were not supposed to be under bed frames as they were not reachable and should not be under mattresses or under beds.During an interview on 4/22/2026 at 2:49 P.M. Director of Nursing (DON) stated if residents needed assistance from their rooms, they were to use the call lights which (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were located within reach of the residents. There was nothing in the policy about wrapping call lights around the handrails.Review of a facility policy and procedures titled Call light, Answering with no revision date showed a Purpose: The purpose of this procedure is to respond to the resident's requests and needs.Procedure:. 5. Make the resident as comfortable as possible. Position the call light within easy reach of the resident.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed ensure Preadmission Screening and Resident Review (PASRR) was accurate for one (Resident #10) out of two Residents sampled for PASRR. Review of Resident #10's admission record revealed the resident was admitted on [DATE]. The record included diagnoses not limited to schizoaffective disorder, depressive type (onset 8/10/2022), generalized anxiety disorder (onset 8/10/2022), major depressive disorder, recurrent, moderate (10/03/2022), and insomnia (onset 7/11/2025).Review of Resident #10's Minimum Data Set (MDS), dated [DATE] for Medications, revealed the resident is taking an antidepressant and antipsychotic regularly.Review of Resident #10's psychiatric notes dated 4/15/2026 revealed Resident #10 had a diagnosis of schizoaffective disorder, depression, anxiety, and insomnia. Diagnoses Rationale and Justifications for Resident #10's schizoaffective diagnosis revealed the resident's history shows the resident has chronic and consistent psychosis. These symptoms cause significant distress and functional impairment to the patient. The resident has had a history of psychosis for more than one month, causing emotional and behavioral disturbance for six months or more.Review of the Level 1 PASRR dated 9/6/2024 revealed in section I: Anxiety disorder, depressive disorder, and schizoaffective disorder were marked under Section A mental illness (MI) or suspected MI. Section II: Other Indications for PASRR Screen Decision- Making questions 1 through 7 were marked no. Section III: PASRR Screen Provision admission or Hospital Discharge Exemption Not a provisional admission was marked no. Section IV: PASRR Screen Completion, Individual may be admitted to an Nursing Facility (check on of the following): No diagnosis or suspicion of Serious Mental Illness or Intellectual Disability indicated.The review showed a level II PASRR was not submitted for consideration.On 4/23/26 at 12:45 p.m., an interview was conducted with the Director of Nursing (DON). She stated she and the Assistant Director of Nursing (ADON) share the responsibility of completing PASRR's. Upon admission, the Minimum Data Set (MDS) Coordinator reviews all of the resident's diagnosis and identifies the MI diagnoses. The DON stated she speaks with the resident's physician, psychiatrist, and family to identify additional information regarding the resident's MI's. She uses this information to fill out the PASRR. The DON reviewed Resident #10's electronic health record and confirmed anxiety disorder, depression disorder, and schizoaffective disorder were marked in Section I. She stated these MI's could potentially be considered serious MI's. She stated a level II was not submitted for the resident because the system did not trigger a level II. She stated she was not aware if Resident #10 had a history of functional limitations as result of their MI's when she marked no to the questions in Section II.Review of an undated facility policy, titled Policy for PASRR, revealed, Policy: The Admissions Coordinator/ Designee is responsible for ensuring that the Level I PASRR Screen and Level II PASRR Evaluation and Determination, if applicable, are completed prior to admission. Procedure: 2. A Level I PASRR must be fully and accurately completed and distributed in accordance with Rule 59G-1.040, F.A.C. Upon or prior to admission, if the facility finds the Level I to be incomplete or inaccurate, a corrected Level I PASRR must be completed by hospital staff or appropriate Nursing facility staff.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, interviews, and record reviews, the facility failed to maintain an effective resident call system in one room (113) of four rooms sampled for call light functioning.Findings included:On 4/20/2026 at 09:55 a.m., the following observations were made.Resident room (113) was observed with a malfunctioning call light.During an interview with Resident #36, on 4/20/2026 at 09:58 a.m., the Resident stated, The call light system has been broke 2-3 times in the past few days. The Resident proceeded to activate the call light and the call light was not functioning. During an interview with the Nursing Home Administrator (NHA) on 4/22/2026 at 2:03 p.m. The NHA stated she was notified of the broken call lights in the above identified room. She stated her expectation is that the maintenance director tests all the call lights and repairs them immediately and that the staff is familiar with the call light policy and that training is provided on call light responses. During an interview with the Director of Maintenance (DOM) on 4/22/2026 at 12:27 p.m., the DOM said he does a monthly audit of the call lights and records his findings and repairs the call system as needed or identified. The DOM said they do not do any other testing of the call light system other than monthly, unless a malfunction is reported by the staff or the residents. DOM said he prioritizes the call light system as an immediate fix and has purchased 26 call buttons in the past six months for repair. During an interview with Staff F, CNA on 04/23/2026 at 9:55 AM, Staff F said call light training consists of ensuring call lights are in reach; answer the call light and don't turn it off until the resident is satisfied. Staff F said if it's broken, they report it verbally or put it in the electronic reporting system. Staff F said they do room rounds and check on the resident and ensure the call light is in reach. Staff F said during the day they do it every one to two hours. Staff F said they check operability by pressing the button and looking above the door to ensure the light is activated and listen for the audible alarm.During an interview with Staff G, CNA, on 04/23/2026 at 10:08 AM , Staff G said she is assigned rooms 109-116. She said she had abuse neglect training today, which was delivered verbally and in writing by the Nursing Home Administrator (NHA). Staff G said she was taught to answer the call light immediately regardless of where the call light is activated. Staff G said she visually ensures the call light is close. She said she looks in the Kardex to ensure that if the resident has mobility issues or needs the call light in a certain spot, it should be noted in the Kardex.Review of an undated facility document titled electronic maintenance work order system weekly tasks schedule showed to conduct a test of the nurse call system.Review of a facility policy titled, call light answering, undated, unsigned showed, the purpose of this procedure is to respond to the resident's requests and needs.Key procedural PointsExplain the call light to the new residentDemonstrate the use of the call light.Ask the resident to return the demonstrationWhen the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.Report all defective call lights to the staff/charge nurse and/or maintenance staff promptly.