

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/18/2024
NAME OF PROVIDER OR SUPPLIER The Club at Lake Gibson		STREET ADDRESS, CITY, STATE, ZIP CODE 855 Carpenters Way Lakeland, FL 33809	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observation, interview, and record review the facility failed to ensure medication was stored appropriately in three out of three medication carts audited and on two out of two units related to unlocked treatment cart, medication on the floor, and medication unlocked on medication carts. Findings included: An observation was conducted on 7/17/24 at 9:50 a.m. of a treatment cart at the end of the 300-hall sitting outside of a resident room. The nurse was inside the room, behind the privacy curtain. The medication cart had 2 intravenous medications and 1 topical medication sitting in the attached plastic side compartment that has no lock. No other staff were in the hall. The nurse, Staff E, Licensed Practical Nurse (LPN) exited the resident room and was interviewed at that time. The nurse said she brought the medications to her cart, and she was going to go hang them up. An observation was conducted on 7/17/24 at 12:27 p.m. of a treatment cart unlocked near the 300-unit nurses' station. No staff were at the nurses' station at the time. The treatment cart remained unlocked at 1:00 p.m. after multiple staff members walked past the cart. An observation was conducted on 7/17/24 at 2:44 p.m. of a medication cart near the 300-unit nurses' station with 6 blister packs of medication sitting on top. There was no nurses at the medication cart. Staff were observed to be approximately 10 feet from the cart talking, but no one was watching the medication cart. An observation was conducted on 7/18/24 at 10:28 a.m. of a yellow pill on the floor in the hall outside of resident room [ROOM NUMBER]. There were no staff members in the hall. Staff H, LPN, was brought to the location. Staff H was not working that hall, but she removed the pill from the floor and believed it was pantoprazole, used for reflux or heartburn. She said the pill should not have been left on the floor, and she would dispose of it properly. An audit was conducted on 7/18/24 at 11:50 a.m. of a medication cart on the 400 unit with Staff F, LPN. The medication cart had 5 loose pills in the drawers of the cart. Staff F confirmed there should be no loose pills in the medication cart. She said night shift was supposed to clean the medication carts. Staff F said she had been educated on picking up loose pills if they dropped. (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	An audit was conducted on 7/18/24 at 12:02 p.m. of a medication cart on the 300 unit with Staff D, Registered Nurse (RN.) The medication was observed to have 13 loose pills throughout the drawers of the cart along with dirt and debris. One drawer contained liquid medication that was spilled in the cart along with a plastic bag with a bottle of liquid Valproic Acid that did not have a lid on it. The lid was in the bottom of the plastic bag. Staff D was not sure why the lid was not on the Valproic Acid. She said she had been educated on loose pills not being allowed in the medication carts. She said if a nurse dropped a pill they should dispose of it properly. Staff D said night shift was responsible for cleaning the carts. An audit was completed on 7/18/24 at 12:20 p.m. on another 300 hall medication cart assigned to Staff E, LPN accompanied by Staff G RN/Unit Manager (UM). The cart contained one individual package of an Atorvastatin 10 mg tablet that was not labeled with a resident name or in a bag with a resident name/prescription. The single pill pack was sitting in a drawer with bottled medications. Staff G said the medication should not be in the cart without a resident name/prescription, and she would remove the medication. An interview was conducted on 7/18/24 at 12:10 p.m. with Staff G, RN/UM. She said management does weekly checks on the medication carts to take out medication for residents that have been discharged and ensure no loose pills were in the cart. She said all nurses should check their own carts and keep them clean. Staff G said when pharmacy delivered new blister packs of medication, the nurses should lock them in the carts immediately. They should not be left on top of the medication cart. She confirmed no medication should be left on the floor or unsecured. Photographic evidence was obtained. An interview was conducted on 7/18/24 at 1:20 p.m. with the Regional Director of Nursing (RDON). She said medications should always be locked in the medication cart or medication room and there should be no loose pills on the floor. She reviewed pictures of medications left on the top and the side medication carts and confirmed that was a problem. Review of a facility policy titled Standards and Guidelines (SG) Medication Storage, revised 10/24/22, showed: Standard: It will be the standard of this facility to store medications, drugs, and biologicals in a safe, secure and orderly manner. Guidelines: 1. Medications, drugs, and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received, unless otherwise necessary. 2. The nursing staff shall be responsible for maintaining medication storage an preparation areas in a clean, safe and sanitary manner. 3. Drug containers that have missing, incomplete, improper or incorrect labels should be returned to the pharmacy for proper labeling before storing. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications, drugs, and biologicals shall be locked when not in use and trays or carts used to transport such items shall not be left unlocked if out of a nurses' view.		