

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

Printed: 03/27/2025
Form Approved OMB
No. 0938-0391

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 01/30/2025
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 - Few	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. 15234 Based on observations, interviews, and record review, the facility failed to ensure medications and biologicals were securely stored for one resident (Resident #43) of one resident sampled for medication storage. Findings included: On 1/28/2025 at 8:05 AM, in Resident #43's room, one tube of topical menthol analgesic was observed on the bedside table and one container of Dimethicone-Zinc Oxide-Vitamin A-Vitamin D ointment was observed on the bedside nightstand. An interview was conducted with Resident #43 following the observation. Resident #43 stated he used the topical menthol analgesic for back pain and he used the Dimethicone-Zinc Oxide-Vitamin A-Vitamin D ointment on his feet. Review of Resident #43's care plan, revision on 1/29/2025, read Observe resident taking his/her medications as needed to ensure proper storage and self administration of medication. Provide a lock box for resident to store medications PRN [as needed]. Obtain order from physician stating that resident is able to self administer medications. Provide education of proper storage of medications and monitor to ensure that resident is properly storing medications. On 1/29/2025 at 9:48 AM, in Resident #43's room, one tube of topical menthol analgesic was observed on the bedside table and one container of Dimethicone-Zinc Oxide-Vitamin A-Vitamin D ointment was observed on the bedside nightstand. During an interview on 1/29/2025 beginning at 9:48 AM, Staff A, Licensed Practical Nurse/Unit Manager confirmed there was one tube of topical menthol analgesic on Resident #43's bedside table and one container of Dimethicone-Zinc Oxide-Vitamin A-Vitamin D ointment on the bedside nightstand. She confirmed the medications should be securely stored in the resident's nightstand that was equipped with a key accessible lock. During an interview on 1/29/2025 at 10:10 AM, the Director of Nursing stated she would expect the resident would follow the rules and have the medications securely stored. (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 - Few	Review of the facility policy titled Storage of Medications, last reviewed 1/31/2024, read Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49289 Based on observations, interviews, and record review, the facility failed to ensure an effective infection control and prevention program to prevent the spread of infection was implemented by 1.) failing to use appropriate personal protective equipment (PPE) while performing care for three residents (#113, #49, and #84) on Enhanced Barrier Precautions on three (Upper 300 Hall, Lower 400 Hall, and Upper 400 Hall) of four facility Halls and 2.) failing to follow professional standards of practice for storage of respiratory equipment for one resident (#269) of four residents observed on respiratory therapy. Findings included: 1.) During an observation on 1/27/2025 at 11:23 AM, Resident #113 had an Enhanced Barrier Precaution (EBP) sign on the wall beside the room door and a storage container containing PPE, including masks, gloves, and gowns, beside Resident #113's door. Staff F, Certified Nursing Assistant (CNA) and Staff G, CNA were observed in the resident's room standing on either side of the resident and assisting with transferring Resident #113 using a sit to stand lift (a specialized medical device designed to assist individuals with limited mobility in transitioning from a sitting to standing position) into his wheelchair. Both staff members were observed wearing gloves and were not wearing gowns. Staff G, CNA combed Resident #113's hair while Staff F, CNA moved the resident's urinary catheter bag from the sit to stand device and secured it to the resident's wheelchair. Staff G, CNA repositioned Resident #113 in his wheelchair, placed his bedside table within reach, gathered a bag of dirty linen and trash bag from the trash can, exited the room, and proceeded down the hallway to the dirty utility room. Review of the signage on Resident #113's door showed, STOP: Enhanced Barrier Precautions. Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities .Transferring, Changing Linens, Device care use: Central line, urinary catheter, feeding tube, wound care: any skin opening requiring a dressing. Review of the medical record showed Resident #113 was admitted on [DATE] with diagnoses including wedge compression fracture of the second thoracic vertebra, malignant neoplasm of the bladder, and benign prostatic hyperplasia with lower urinary tract symptoms. Review of Resident #113's January 2025 physician's orders revealed an order dated 12/12/2024, for Isolation: Enhanced Barrier Precautions (EBP) Foley Cath [catheter] use every shift EBP [Enhanced Barrier Precautions]. During an interview on 1/29/2025 at 11:09 AM, Staff F, CNA stated, I wasn't wearing a gown when I was taking care of him [Resident #113] or transferring him. I should have been. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/29/2025 at 11:10 AM, Staff G, CNA stated, I wasn't wearing a gown either when taking care of [Resident #113]. I need to wear a gown when they are on EBP and have a catheter, I should have. I'm sorry. During an interview on 1/29/2025 at 9:34 AM, the Director of Nursing (DON) stated, I expect staff to be following the EBP signs on the doors and wearing appropriate PPE when performing care. I expect the staff to be wearing gowns when performing direct care for a resident with a [urinary] catheter. They should have been wearing full gear. 45576 Review of Resident #49's clinical record documented admission to the facility on [DATE] with a diagnosis of neuromuscular dysfunction of the bladder. Review of Resident #49's January 2025 physician orders revealed the following: - An order dated 8/2/2023, Suprapubic insertion site: cleanse with NS [normal saline] pat dry and cover with split sponge every day shift. - An order dated 4/2/2024, Enhanced Barrier Precautions every shift. - An order dated 12/2/2024, Cleanse Wound to left distal ankle with NS [normal saline], apply calcium alginate, Santyl, cover with dry dressing. One time a day for wound care. During an observation on 1/29/2025 at 8:30 AM, there was signage posted outside of Resident #49's room above his room number and of PPE, including gloves, masks, and gowns, hanging in a caddy on the residents door. The signage read STOP enhanced barrier precautions everyone must: .wear gloves and a gown for the following high-contact resident care activities.wound care: any skin opening requiring a dressing . On 1/29/2025 at 8:30 AM, Staff B, Registered Nurse (RN) and Staff E, RN Clinical Educator were observed, during care for Resident #49, dressing an open wound to the left distal ankle and cleansing and dressing the resident's supra-public urinary catheter site without donning PPE in accordance with the posted signage. During an interview on 1/29/2025 at 8:50 AM, Staff, B RN stated, Yes, I should have put on PPE prior to conducting wound care. I normally do, you make me nervous. During an interview on 1/29/2025 at 8:53 AM, Staff E, RN Clinical Educator stated, Just came to help her I didn't realize he was on EBP. I thought that was for the other resident, but I know any time we complete wound care we should be dressing out with PPE. I didn't think and I teach this process. Review of Resident #84's clinical record documented admission to the facility 1/20/2022 with a diagnosis of encounter for attention to gastrostomy. Review of Resident #84's January 2025 physician orders revealed the following: (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An order dated 1/27/2024, Enteral Feed order .Jevity 1.5 at 75 cc [cubic centimeters]/hour via feeding tube for 10 hours with auto flush at 200cc/hour every 4 hours. On at 5pm till 750 ml [milliliters] total volume infused. - An order dated 12/21/2024, Enhanced Barrier Precautions-PEG [percutaneous endoscopic gastrostomy] tube. During an observation on 1/29/2025 at 9:27 AM, there was signage posted on the outside of Resident #84's room above his room number with PPE, including gloves, masks, and gowns in a storage container under the signage by the resident's door. The signage read STOP enhanced barrier precautions everyone must: . wear gloves and a gown for the following high-contact resident care activities.Device care or use : .feeding tube . During an observation on 1/29/2025 at 9:27 AM, Staff D, Licensed Practical Nurse (LPN) initiated enteral feeding for Resident #84. After aspirating gastric contents from the gastrostomy tube, Staff D, LPN initiated Jevity 1.5 at 75 ml/hour via gastric pump. No PPE was donned during the observation. During an interview on 1/29/2025 at 9:30 AM, Staff A, LPN Nurse Manager stated, Any residents on Enhanced Barrier Precautions, staff have to wear PPE which includes a mask, gown, and gloves, when providing direct patient care. That includes wound care and gastrostomy feeding for infection control. During an interview on 1/29/2025 09:45 AM, Staff D, LPN stated, I should have used PPE any resident on Enhance Barrier Precautions we have to dress out when providing direct care. During an interview on 1/29/2025 at 9:48 AM, the DON stated it is her expectation a gown, gloves, and mask is utilized when providing gastrostomy feedings and wound care to resident's on EBP. Review of the policy number 21.08.003 titled Enhanced Barrier Precautions, last reviewed 3/31/2024, showed: Standard: Prevention, containment, and eradication measures, including the use of Enhanced Barrier Precautions (EBP) are indicated, as informed by the Centers for Disease Control and Prevention (CDC), to prevent and control the spread of novel, targeted, and emerging multi-drug-resistant microorganisms, defined as CDC-targeted MDROs. The prevention and control of CDC-targeted MDROs by this center is considered a resident safety measure. Enhanced Barrier Precautions (EBP). Enhanced Barrier Precautions are a transmission based approach that falls between Standard and Contact Precautions. Examples of high-contact resident care activities requiring a gown and glove use include: Transferring, changing linen, performing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube .wound care: any skin opening requiring a dressing. 2.) Review of Resident #269's clinical record documented admission to the facility on [DATE] with a diagnosis of chronic pulmonary edema. Review of Resident #269's January 2025 physician orders revealed, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG[milligrams]/3ML, 3 ml inhale orally every 6 hours for shortness of breath (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 1/27/2025 at 10:10 AM, Resident #269's nebulizer mask was uncovered and lying on the bedside table. An interview was conducted with Resident #269 following the interview. Resident #269 stated, I normally take my nebulizer twice a day. They gave me the treatment around 3:30 AM. Review of Resident #269's Medication Administration Record showed Ipratropium-Albuterol Solution was administered on 1/27/2025 at 5:00 AM and 11:00 AM. During an observation on 1/27/2025 at 2:20 PM, Resident #269's nebulizer mask was uncovered and lying on a table. During an interview on 1/27/2025 at 2:31PM, Staff C, LPN stated, the nebulizer should have been placed in a bag for storage. During an interview on 1/27/2025 at 2:55 PM, Staff A, LPN stated, nebulizers are to be placed in a bag for infection control after the procedure has been completed. During an interview on 1/28/2025 at 10:50 AM, the DON stated, nebulizer needs to be placed in a bag for storage to prevent contamination, until next use. Photographic Evidence Obtained		