Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65320C	A. BUILDING: _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND NURSING & REHABILITATION	1919 LAKELAND HILLS BLVD LAKELAND, FL 33805

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N 000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2024014135, 2024015562, 2024015980,2025000650, 2025001182 and 2025002105 was conducted on through at Lakeland Nursing and Rehabilitation. Deficiencies were identified at the time of survey. A Class I deficiency was identified at N201 related to complaint number 2025001182. Class I deficiencies are those which the agency determines presents an imminent danger to the residents or guests of the facility or a substantial probability that or serious physical harm would result therefrom. The facility resident census at the beginning of the survey was 171. The Class I started on . The facility administration was informed of the Class I on at 4:03 p.m.	N 000		
N 031 SS=D	400.151( ) FS; 59A-4.106(1)(b) FAC Resident Contracts 400.151, F.S. (1) The presence of each resident in a facility shall be covered by a contract, executed by the licensee and the resident or his or her designee or legal representative at the time of admission or prior thereto and at the expiration of the term of a previous contract, and modified by the licensee and the resident or his or her designee or legal representative at the time the source of payment for the resident's care changes. Each party to the contract is entitled to a duplicate original thereof,	N 031		

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N 031	Continued From page 1 printed in boldfaced type, and the licensee shall keep on file all contracts which it has with residents. The licensee may not destroy or otherwise dispose of any such contract until 5 years after its expiration or such longer period as may be provided in the rules of the agency. Microfilmed records or records reproduced by a similar process of duplication may be kept in lieu of the original records. (2) Each contract to which this section applies shall contain express provisions specifically setting forth the services and accommodations to be provided by the licensee, the rates or charges therefor, bed reservation and refund policies, and any other matters which the parties deem appropriate. The licensee shall attach to the contract a list of services and supplies available but not covered by the per diem rate of the facility or by Titles XVIII and XIX of the Social Security Act and the standard charge to the resident for each item. The licensee shall provide written notification to each party to the contract of any changes in any attachment thereto, no fewer than 14 days in advance of the effective date of those changes. The agency shall specify by rule an alternative method for notification of changes in the cost of supplies. If the resident is a party to the contract, the licensee shall provide him or her with a written and oral notification of the changes. 59A-4.106(1)(b), FAC (b) Each resident admitted to the facility must have a contract as required by Section 400.151, F.S., which includes the following: 1. A list of services and supplies, complete with a list of standard charges for those services and supplies, available to the resident, but not covered by the facility's per diem or by Title XVIII	N 031		

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N 031	Continued From page 2 and Title XIX of the Social Security Act and a copy of the bed reservation and refund policies of the facility. 2. When a resident is in a facility offering continuing care, and is transferred from independent living or assisted living to the nursing home section, a new contract need not be executed; an addendum must be attached to describe any additional services, supplies or costs not included in the most recent contract that is in effect. This Statute or Rule is not met as evidenced by: Based on resident record review and interview, the facility did not ensure that admission paperwork, including admission agreements and consents were in the resident records for four (#7, #9, #11 and #15) of 16 sampled residents. Findings Included: Review of the records for Resident #7, # 9, #11 and # 15 revealed no documentation of admission paperwork including admission consents and admission agreements/contracts. On at 4 00 p.m., the Administrator confirmed the admission paperwork for these four residents could not be located. She stated she had no idea what happened to the documents and the facility was now in the process of obtaining new admission paperwork. CLASS III	N 031	1. Immediate action(s) taken for the resident(s) found to have been affected include: Facility contacted resident/representative and obtained new admission agreement for residents #7, #9, #11 and #15. 2. Identification of other residents having the potential to be affected: A facility wide audit was completed for all in-house residents. Review of medical records to verify and ensure admissions agreements were completed for all residents. Any resident found not to have an agreement was completed. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: Admissions department staff were educated to ensure admission agreements are completed and signed in a timely manner. Audits will be put in place.	

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N 031	Continued From page 3	N 031	4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Director of Admissions/designee will conduct quality review of resident records to ensure admission agreements are completed and uploaded into resident records. Records of newly admitted residents will be monitored for Admission agreements completion and upload. Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.	
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient	N 101		

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N 101	Continued From page 4 information to clearly identify the resident, his or her diagnosis and treatment, and results. This Statute or Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure documentation was accurate and complete for one (#4) of one resident related to the documentation of a change in condition resulting in -. ( ) being administered. Findings included: Review of Resident #4's Admission Record revealed the resident was most recently admitted to the facility on . The record included diagnoses of idiopathic , , acute , failure with , unspecified , unspecified , and dependence on supplemental . Review of Resident #4's clinical record showed a Hospital Transfer Form, dated at 1:40 p.m. showed the resident was a Full Code. Review of a Situation, Background, Appearance, and Review/Notify (SBAR) assessment dated at 9:37 a.m. showed notification to the provider of resident change in condition related to food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts). Review of Resident #4's progress note, dated at 1:56 p.m. showed the resident was transferred from one room to another at 1:30 p.m., and the resident was found unresponsive. Emergency Medical Transport (EMT) was called, and the physician and family were notified.	N 101	1. Immediate action(s) taken for the resident(s) found to have been affected include: Review of resident #4s clinical record. Resident #4 was transferred out to Lakeland Regional Medical Center. Upon record review resident #4 was transferred out and expired, therefore, she no longer resides at Lakeland Nursing and Rehab. Late entry regarding the event was input in Resident #4s clinical record. 2. Identification of other residents having the potential to be affected: Quality review of code blue events to ensure record contains documentation of , per advance directive order. Review of code blue events for the past 90 days to ensure change of condition, transfer forms, if applicable, MD notification, and resident representative notification. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: Director of Clinical Services reeducated on documentation policy. All licensed nurses educated on proper documentation protocols, code blue events, change of condition and transfer forms. Code blue events, change of conditions, and transfer forms will be reviewed in the morning clinical meeting with follow-up as necessary. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur:	

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N 101	Continued From page 5 An interview was conducted on at 3:22 p.m. with the Director of Nursing (DON). The DON reported Resident #4 was transferred on , and stated the resident had initiated in the facility, and the physician present in the facility assisted. She stated the expectation was for staff to document was initiated and EMT was called in the clinical record. A follow-up interview with the DON on at 3:58 p.m. confirmed the clinical record and transfer form did not reveal the resident had received . Review of the policy - Documentation in Medical Record, implemented , showed "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation." The compliance guidelines included: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3c. Documentation shall be timely and in chronological order. CLASS III	N 101	The Director of Nursing/ Designee to complete quality review of any code blue event to make certain record reflects proper documentation. Audits of code blue events, change of condition, transfer forms, if applicable, MD notification, and resident representative notification. Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.	
N 201 SS=J	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate	N 201		

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N 201	Continued From page 6 health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide adequate and appropriate protective and support services to prevent accident hazards to prevent a with injury for one resident (#6) of 19 ambulatory residents in the memory care unit. The facility failed to replace a clean-out drain located in a high traffic area of the facility's memory care unit and failed to promptly and effectively address flooring issues, resulting in an unsafe walkway, where Resident #6 , sustained a to the right (top of bone) requiring a transfer to a higher level of care, and surgical intervention of a right , , . The injuries to Resident #6 caused a significant decline in her ability to ambulate and complete activities of daily living (ADLs) at her prior functional level. Findings included: A review of Resident #6's admission record revealed the resident was , , originally admitted to the facility on , with a recent hospital stay from to . The record showed diagnoses to include a displaced of base of of right subsequent encounter for closed with routine healing, aftercare following , replacement surgery, difficulty in walking, presence of right ,	N 201	Immediate action(s) taken for the resident(s) found to have been affected include: Flooring was repaired to prevent further accidents. Resident # 6 is no longer resides in the facility. 2. Identification of other residents having the potential to be affected: NHA and Director of Maintenance performed rounds of the facility to identify any hazardous areas. Identified hazards removed and/or repaired. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: DCS/Designee provided education on Accidents and Supervision policy, redirecting residents with from environmental hazards, and recognizing and reporting potential environmental hazards. An additional staff member has been assigned to memory care unit as Hall Monitor to increase supervision. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: Administrator/Director of Maintenance/Designee will complete facility assessment rounds to make certain	

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N 201	Continued From page 7 , and and other classified elsewhere unspecified severity with agitation. A review of the Situation, Background, Appearance, and Review (SBAR) Communication Form and Progress Note revealed Resident #6 had a change in condition of a on . The Situation section of the form documented "status post , trip and in hallway, complaining of lower and right ." The Background section documented the resident has new , with an intensity of 9 out of 10 (10 being the worst). The Appearance section documented "status post in hallway, left in place due to , on movement. 911 called." The Review and Notify section documented that the primary care clinician was notified on at 8:40 a.m. with recommendations to send to the Emergency Room (ER) for evaluation. The Family Member (FM) was notified on at 8:44 a.m. A review of Resident #6's hospital History and Physical Report, dated at 12:59 p.m. revealed this female had a medical history of , dyslipidemia, and [ ]. The nursing home resident, presented to the hospital from the nursing home after a . The patient was found on the ground and complaining of right . The patient's baseline was , and she could only recognize her [FM]. The completed imaging studies, on at 10:44 a.m. showed a right . The Computed Scan (CT) of the without contrast, on at 10:04 a.m., revealed " right with angulation and mild displacement." The results of the right and right , with showed "normal ." A review of a hospital consultation note dated	N 201	facility is free of hazards once weekly x 8 weeks; then every w weekly x 4 weeks and will continue weekly rounds ongoing. Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.	

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N 201	Continued From page 8 at 6:04 p.m. showed the resident was complaining of right , , and the physical examination showed the right lower extremity was shortened and externally rotated. The assessment/plan showed resident "would benefit from , intervention of the right , in order to provide stability to the and promote satisfactory healing, to improve , , to facilitate early motion and mobilization and to prevent complications associated with prolonged bedrest." The risks, benefits, complications, and alternatives treatments were explained to the patient and FM. This included "the possibilities of , , , reaction to , compromise, or dying on the table, incomplete relief of symptoms, and , or stiffness." A review of the , report on at 9:08 a.m., showed Resident #6 had undergone a right , , . The post- , results showed the , was "well-seated" with no evidence of hardware loosening or failure. A review of Resident #6's clinical record at the facility prior to the with a revealed a quarterly Minimum Data Set (MDS), dated . The pattern (Section C) showed a Brief Interview of Mental Status ( ) score of 9, indicating moderate . The functional abilities assessment (Section GG) revealed the resident was independent with eating, oral and toileting hygiene, and upper/lower body . The resident required supervision with shower/bathing self, putting on/taking off footwear, and personal hygiene. The resident was independent with rolling left to right, sitting to lying, lying to sitting, sit to stand, transferring from chair/bed-to-chair, toilet transferring, walking 10 and walking 50 with two turns. The resident required partial	N 201		

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N 201	Continued From page 9 assistance with tub/shower transfer, and supervision with walking 150 . The resident was always of and frequently of (Section H). The health conditions assessment (Section J) revealed the resident had no 5 days prior to the assessment, and had not since admission/entry, reentry, or prior assessment. A review of Resident #6's last ( ) Discharge Summary (prior to the with a) was dated and showed the resident was able to ambulate with no assistive device with modified independence ( ) for up to 300 ft. or as tolerated on level surface with verbal cues for directional changes. A review of Resident #6's last Risk Evaluation (prior to the with a) was dated for a last known on with a risk score of 9 (a score of 8 or higher indicates a risk). A review of a facility note dated at 5:30 p.m., showed Resident #6 returned to the facility from the hospital following a right (related to the on). The record showed the resident was in whenever touched. The resident had a surgical on the right . A review of a Risk Evaluation conducted on at 5:39 p.m. showed the last known was on . The resident's risk score was 17. A review of a Evaluation dated showed Resident #6's prior level of function (PLOF) for bed mobility and transfers was independent with a baseline on of total assistance. The PLOF for walking was supervision with rolling walker up to 200 with a baseline on of unable. A review of Resident #6's 5-day MDS (post and hospitalization), dated , revealed the	N 201		

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N 201	Continued From page 10 resident had a score of 00, indicating severe , . The functional abilities assessment showed the resident was dependent on eating, oral and toileting hygiene, shower/bathing, upper/lower body , and putting on/taking off footwear. The resident was dependent for rolling left to right, sitting to lying, lying to sitting, sit to stand, transferring from chair/bed-to-chair, toilet transferring, car transferring, walking 10 , walking 50 with two turns, and walking 150 . The assessment showed the resident was using a manual wheelchair. The resident was of and . The health conditions revealed frequent , , no in the last month prior to admission/entry or reentry, no related to a in the 6 months prior to admission/entry or reentry and had major surgery during the 100 days prior to admission. A review of Resident #6's care plan initiated on and revised on revealed the resident was at risk for related to history of , poor safety awareness, , , , medication use, and . The interventions for the care plan included: Ensure resident has a safe environment: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position; handrails on walls, personal items within reach) initiated on . Keep environment/walkway free of trip hazards initiated on and revised on . Family to assist with decluttering room for safety initiated on and revised on . Scoop mattress initiated on .	N 201		

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N 201	Continued From page 11	N 201		

During a facility tour on at 10:30 a.m. an area of rough and uneven concrete approximately 3ft ( ) x 2 ft in the middle of the corridor of the 200-hall located inside the memory care unit. The uneven concrete area had a drain cap located near the middle that was raised. The concrete area was a known high-traffic area, outside of the secured memory care dining room, the nurses' station, and just outside of Resident #6's room.

A review of an electronic work order created on at 6:31 p.m. by Staff G, Licensed Practical Nurse (LPN) revealed "clean out cover missing," location 200 hallway, priority level medium, and a note/comment to "repair drain on 200 hallway asap [as soon as possible]." The status of the order was updated by the Director of Maintenance (DOM) on at 2:49 p.m. as "Set to Completed." A Room Audit Form, for "Project Clean OUT 200 Hall" with a start date of revealed daily notes monitoring the clean out cover area from to documented by the DOM. The first entry on the log, dated , showed the (DOM) placed a metal sheet cover over the drain opening with tape. The entry on , the day the work order status was updated, showed a visual inspection was done in the morning and fresh tape was applied that evening. None of the entries between and showed any additional work outside of visual inspection and applications of fresh tape was completed. A review of the audit log revealed no documentation to show the area was visually inspected to ensure safety of residents, staff, and visitors on , , , , , , , , , , , , , , , and . The log showed on "morning - Resident [#6] , fresh tape -plumber called -Received Quote & Sent." The

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N 201	Continued From page 12 log showed on "evening - Job completed." A review of an email dated confirmed the plumbing company had completed a repair of the area on the 200 hall on , 4 days after Resident #6 and 37 days after the original work order was created. An interview on at 1:34 p.m. with Staff C, Certified Nursing Assistant (CNA) revealed she witnessed Resident #6's incident on . Staff C, CNA reported Resident #6 was in the hallway with her FM. The resident was attempting to detach herself from tape on the floor in the unrepaired plumbing area that was covered with concrete. The staff member stated the tape was not holding anything down. Staff C saw Resident #6 lose her balance and . Review of a written statement by Staff C, CNA dated at 8:30 a.m. showed Staff C was coming down the hall with a breakfast tray and witnessed Resident #6 trip and over an area on the floor. The tape was coming up and Resident #6's got caught on it. On at 9:45 a.m., an interview was conducted with the DOM. He stated on 200-hall, the memory care unit, a resident had pulled the clean-out cap off, on . The DOM reported "roping" the area off and cutting a metal piece to fit on top of the missing cap. He stated this was done after Resident #6 had . The DOM stated the facility had plumbers come in on . The DOM stated from to , he had put several patches on the area, and went every day to make sure it was secure and safe. The DOM reported the plumbers removed the tile all the way around the clean out cap, leaving a cemented patch. On at 10:46 a.m., the DOM observed the 200 hall and showed the area where Resident #6	N 201		

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N 201	Continued From page 13	N 201		

had in the hallway. The area was near the nursing station in the 200-hall and just outside of Resident 6's room at that time of the incident. The DOM observed an additional area of missing floor tiles on the 200 hall and stated the facility had just received the diamond blades to smooth out the concrete. He stated the plumbers had to remove the tiles to fix a plumbing issue. During the time of this interview, the DOM confirmed the area where Resident #6 had was still uneven due to the concrete patch left by the plumbers on .

A follow-up interview on beginning at 3:05 p.m. with the DOM revealed the rough concrete patch observed during the survey beginning on was part of the repair. The DOM stated he had to research a replacement cap since the missing cover was so old. The DOM stated the plumber did not have a cap to fit the iron piping, so the plumber had to make the hole bigger and cut pipe to fix it. The DOM revealed this repair happened in the middle of . The DOM stated he had put a metal plate on the area trying to save the company money in . The DOM reported he was researching it to try to fix it himself before calling the plumbers in, but after Resident #6's , he was done searching for the replacement and decided to get plumbers in. The DOM stated he felt the location where Resident #6 was safe and felt the [brand name] tape was a good tape to use as a temporary fix. The DOM reported the diamond grinding wheel, needed to smooth out concrete, had been ordered and came in "last week." The DOM said he had looked at local merchants for the grinding wheel, but they did not have the size needed in stock. The DOM stated the diamond wheel was delivered on , the day before he went on vacation. Review of the online merchant's receipt for the 4.5-inch

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N 201	Continued From page 14 diamond concrete grinding wheel showed the order was placed on and shipped on . At the time of this interview, the area where Resident #6 was still not fully repaired leaving a rough and uneven flooring surface in this high traffic area. During an interview on at 2:15 p.m., the Director of Nursing (DON) stated Resident #6 had been ambulating in the hallway with a family member and her kind of got stuck on tape. The DON reported the FM grabbed the resident had pulled her, then the resident lost her balance and . The DON stated the resident had a history of , and because of right , , the resident was left on floor. The DON stated she interviewed Staff B/CNA, Staff C/CNA, and Staff E, Licensed Practical Nurse (LPN). The DON stated Staff E, LPN was sitting at the desk and did not witness the , but heard the resident call out and saw her lying on the right side. The DON confirmed Resident #6 suffered a , was transferred out to the hospital, had surgery and came to the facility. The DON stated Resident #6 had suffered a previous on . She stated the resident had a big chair in her room at the time so the family "decluttered" the room and when the resident started ambulating, the facility ensured the environment was free of clutter and slip hazards to prevent additional . An interview was conducted on at 12:00 p.m. with Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member described the area of concrete as similar to other drains on unit, showing a circular drain with a square metal outer plate. Staff J, LPN/UM stated the residents on the unit like to pick at it and had pulled the square metal plate up. Staff J, LPN/UM stated	N 201		

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N 201	Continued From page 15 maintenance had covered the area with a metal square that was approximately the same size as the missing plate and secured it to the floor with yellow and black striped industrial tape so it would be recognized as a caution area. Staff J, LPN/UM stated she doubted the residents in the memory care unit would have recognized the tape as a caution area. The staff member stated the concrete area was a high-traffic area as it was between the dining room, Resident #6's room, and the nursing station on the memory care unit. Staff J, LPN/UM stated they had a lot of residents up and down the hallways due to on the unit. Staff J, LPN/UM said she could only report it to maintenance, and then it was out of her . Staff J, LPN/UM stated the metal and tape was a hazard, and during the repair period, the area had become larger in size. A review of a work order dated at 2:24 p.m. showed Staff J, LPN/UM reported missing tile on the floor of the 200 hallway with a medium priority level. The work order was acknowledged by the DOM on at 3:30 p.m. with a status of "Set to-In-Progress." The work order was updated on at 2:17 p.m. by the DOM with a status of "Set to completed." On at 10:18 a.m., a second area in hall 200 towards the front of the facility, near the janitor supply closet #3 was observed with 12 missing tiles. The area was in the walking path of residents in the memory care unit. The area had a raised drain with a cap near the middle of it. An immediate interview was conducted with Staff B, Certified Nursing Assistant (CNA) who confirmed the area had been in disrepair for a "long time" and estimated it to be approximately 6 to 8 months.	N 201		

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N 201	Continued From page 16 On at 10:38 a.m., the entrance ramp to the 400-hall was observed missing five full carpet squares (approximately 2 ft x 2 ft) and 5 half carpet squares leaving exposed concrete with a raised drain that was not level to the concrete, and the carpet that remained was not level with the concrete. A yellow traffic cone was placed in the corner from the hallway to the ramp. This area was the inside entrance for residents, staff and visitors to access the 400-hall and used frequently by residents with ambulation devices and wheelchairs. On at 2:04 p.m., the Regional DOM reported not being aware of the flooring issue. The Regional DOM stated depending on severity, if something could not be handled in-house the facility contacted vendors for repairs. The Regional DOM expected something to be implemented promptly, within one to two weeks for the safety of the residents. During a facility tour of the 200 hall on at 2:21 p.m. with the Nursing Home Administrator (NHA), revealed tiles that were popping up on the edges where the facility had replaced flooring using old tiles. The NHA confirmed the area was a hazard for someone with a shuffling gait. The NHA stated the tiles needed to be put down again and better. The NHA stated her expectation was an immediate fix for any hazard affecting residents. The NHA observed the area where Resident #6 and stated she expected the area to be safe for the residents. The NHA stated it was unacceptable to wait to repair the floors. Review of the Prevention Program, implemented on , revealed "Each resident will be assessed for risk and will receive care and services in accordance with their	N 201		

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N 201	Continued From page 17 individualized level of risk to minimize the likelihood of ." The policy defined a " " as an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere." The policy explanation and compliance guidelines showed the facility utilized a standardized risk assessment for determining a resident's risk. Low/moderate risk protocols include implementation of universal environmental interventions that decrease the risk of a resident falling, including, but not limited to: A clear pathway to the bathroom and bedroom doors. A review of the policy titled, Safe and Homelike Environment, implemented , revealed: "In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and home like environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk." Definitions included: "Environment" refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, , , areas, and activity areas; "Orderly" is defined as an uncluttered physical environment that is neat and well-kept. Policy explanation and compliance guidelines: Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.	N 201		

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N 201	Continued From page 18 General Considerations: Report any unresolved environmental concerns to the Administrator. CLASS I	N 201		
N 203 SS=F	400.022(1)(n), FS Right to be Treated with Dignity (n) The right to be treated courteously, fairly, and with the fullest measure of dignity and to receive a written statement and an oral explanation of the services provided by the licensee, including those required to be offered on an as-needed basis. This Statute or Rule is not met as evidenced by: Based on observation of videos posted on social media platforms without consent, review of resident records, policy and procedures review, and staff, family and resident interviews, the facility did not ensure 10 of 16 sampled residents (#7, #8, #9, #10, #11, #12, #13, #14, #15, and #16) received courteous treatment with the fullest measure of dignity.. Findings Included: Review of the facility's policy titled Social Media Use, implemented and revised showed: "It is the policy of this company to avoid inappropriate use of social media and to protect the residents, staff, visitors, volunteers and practitioners of this facility against misuse of social media content. Taking, keeping, or distributing unauthorized photographs or recordings of residents through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality. Staff members must recognize	N 203	1. Immediate action(s) taken for the resident(s) found to have been affected include: Facility contacted residents□ responsible parties/representatives/families of residents #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16 to notify them that the residents were posted on social media by a staff member, without the facility□s knowledge. Staff members were advised to remove all resident-related content from social media. All videos found were reported to the social media to remove videos. The legal department at Tik Tok was contacted to remove videos. Staff member was terminated. 2. Identification of other residents having the potential to be affected: Multiple social media platforms reviewed to identify any postings of facility residents. Facility-wide audit of all residents currently residing in the facility to verify photo consents are signed and present in the medical record. The photo consent form	

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N 203	Continued From page 19 that they have an ethical and legal ␣ to maintain resident privacy and confidentiality at all times. Policy Explanation and Compliance guidelines: 1. Employees are strictly prohibited from transmitting by way of any electronic media any resident-related image or information that may be reasonably , to violate resident rights to confidentiality or privacy. This includes information that could degrade or embarrass the resident. 2. Photographs or recordings of a resident and/or his or her private space without the residents' or designated representatives; written consent, is prohibited. Examples include taking unauthorized photographs/videos of: a. A resident's room or furnishings (which may or may not include the resident). b. A resident eating in the dining room. c. A resident participating in an activity in the common area. d. Taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment. 3. Employees will not post or share posts that would disseminate any personal or medical record information regarding a resident. This would include medical, social, fund accounts, automated electronic or other types of personal resident information, as well as gender identity and orientation. 4. Employees will maintain professional boundaries in the use of social media. 5. Employees are not to share company data or information on social media. 6. Employees will refrain from making offensive remarks on social media about their employer, coworkers, visitors, volunteers or practitioners. This includes making threats, harassing, and using profane, obscene, , explicit, racially	N 203	was revamped to include social media posting. The consent form does not permit staff to post on their personal pages. The consent clearly states for us on Lakeland Nursing and Rehab OPCO, LLCs official social media accounts. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: RDCS/DCS/Designee re-educated staff on facility policies to include , Neglect, , ; Resident Rights; Social Media; and Personal Cell Phone Use. NHA has since created an official social media page for authorized facility-related content and is the authorized administrator of the page. Resident records will be reviewed for photo and social media consent prior to any posting of content. No phones are allowed to be out in patient care areas. Nursing Home Administrator/Designee will search social media weekly for postings related to our facility. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Admissions Director/Designee will conduct an audit of new admission records to make certain records contain Photo Consent Form five times a week X 4 weeks, 3 times a week X 4 weeks, twice weekly X 4 weeks, then weekly and PRN as indicated. The Administrator/Designee will conduct reviews of social media (Tik Tok, Facebook, Instagram) weekly x 8 weeks and every 2 weeks x 1 month, then monthly x 3 months and quarterly or PRN as indicated.	

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N 203	Continued From page 20 derogatory, or homophobic comments. 7. Employees will not post content or otherwise speak on behalf of the employer unless authorized to do so. Any employee who violates this policy may be subject to disciplinary action, up to and including termination." Review and observation of videos posted on social media platforms on , , , , , and additional dates that could not be determined showed Resident #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16 dancing or in the background of the videos, which also contained various staff members. These videos were recorded in various locations within the facility to include the secure memory care unit and hallways with room numbers where residents resided. Review of the social media videos showed they were originally posted by Staff I, Admissions Coordinator and had been reposted and edited by an unknown number of users on social media. Multiple videos were shown to share the first name of Resident #10 by Staff I, Admissions Coordinator, which was then included into other videos posted by unknown users across various social media platforms. A web browser search using Staff I's social media username showed videos containing Resident #10 with over 406,600 views, 70,600 likes, and 2,456 comments. The original videos were found to be removed; however, they could still be viewed under the search engine preview using Staff I's social media username. Review of the admission record for Resident #10 revealed she had resided in the facility since 2023 and lived in the secure memory care unit during the period the videos were posted. Resident #10's admission record included diagnoses of due to known physiological	N 203	Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.	

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N 203	Continued From page 21 condition with mixed features, in other classified elsewhere-severe with disturbance, brief , major - recurrent severe with symptoms, and . Review of the annual minimum data set (MDS) assessment completed on showed a brief interview of mental status score ( ) score of 3, indicating severe . The quarterly MDS completed also showed a indicating severe . A phone interview was conducted with Resident #10's Family Member (FM) on at 2:31 p.m. The FM stated she was informed by facility administration around a week and a half ago about videos on [name of social media platform]. The FM reported receiving a call from an unknown nurse a week prior to that, telling her about the videos. The FM stated she would not have consented to Resident #10 being posted on social media and stated, "absolutely not." Review of the admission record for Resident #8 revealed she had resided in the facility since 2023 and lived in the secure unit during the period the videos were posted. Resident #8's diagnoses included major , -recurrent/moderate, due to known physiological condition with mixed features, , adult , unspecified -unspecified severity, with other behavioral disturbance, and . Review of the quarterly MDS assessment completed on showed a score of 00, indicating severe . A phone interview was conducted with Resident #8's FM on at 2:19 p.m. She stated she was notified this week of videos being posted on social media, but did not know what social	N 203		

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N 203	Continued From page 22 media pages. She was told it was just dancing. She stated no one had contacted her for consent prior to the posting of videos on social media. Review of the admission record for Resident #14 revealed he had resided in the facility since 2022 and lived in the secure unit during the period the videos were posted. Resident #8's diagnoses included , , , generalized , unspecified protein calorie due to known physiological condition, and in other classified elsewhere with , , disturbance. A determination of incapacity form was signed by the physician on . Review of the quarterly MDS assessments completed on and showed a score of 00, indicating severe , , . A phone interview was conducted with Resident #14's Health Care Surrogate (HCS) on at 12:54 p.m. The HCS stated Resident #14 was unable to give consent due to and he did not give consent nor was he asked to provide consent for Resident #14 to be posted on social media. He stated he was called this week and told that the videos were on the facility's social media page. He was not told the videos were posted on social media platforms and said he would not have given consent for that. Review of the admission record for Resident #13 revealed she had resided in the facility since , of 2024 and lived in the secure unit when the videos were posted. Resident #13's diagnoses included unspecified , , disturbance, disturbance, and , . A physician attestation of incapacity form dated showed the resident was , unable to communicate a willful and knowing health decision.	N 203		

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N 203	Continued From page 23 Review of a quarterly MDS, dated showed the resident had short term and long term memory problems and moderately , decision making skills. A phone interview was conducted with Resident #13's FM on at 1:16 p.m. The FM stated the resident was lucid enough to discuss this matter with. An interview was conducted with Resident #13 on at 1:43 p.m. She stated she had not been asked about being on social media postings and did not want to be included on postings. The resident said there was too much information out there, and she wanted to lay low. Review of the admission record for Resident #7 revealed she had resided in the facility on the secured unit since early 2024. Resident #7's diagnoses included unspecified , , , , brief , , and major , . An incapacity statement was signed by the physician on , which showed the resident was incapable of exercising her rights to consent to medical and mental health treatment, to contract, and to make decisions about her social environment or other social aspects of her life. Resident #7's record showed indicated a court appointed guardian was in place. Review of an annual MDS assessment dated showed a score of 00, indicating severe , . Review of Resident #7's record revealed no documentation that her legal guardian consented to the posting of the resident on social media. Review of the admission record for Resident #12 revealed he had resided in the facility's secured unit since with diagnoses to include communication and major	N 203		

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N 203	Continued From page 24 , , A physician attestation of incapacity form dated showed the resident was unable to communicate a willful and knowing health decision. A significant change MDS assessment was completed with a score of 3, indicating severe . A phone interview was conducted with Resident #12's FM on at 2:48 p.m.. The family member stated that did not consent to posting videos of the resident on social media. The FM reported she would have expected to be asked for consent prior to any postings on social media. Review of the admission record for Resident #15 revealed she had resided in the facility's secured unit since 2023 with diagnoses to include unspecified with behavioral disturbance, , major , , and . A physician attestation of incapacity form dated showed the resident was unable to communicate a willful and knowing health decision. Review of the last two quarterly MDS assessments completed and showed a score of 0, indicating severe . Review of Resident #15's record revealed no documentation of consent for social media video postings. Interview with Resident #15's FM on at 11:40 a.m. confirmed he did not provide consent but did not express concerns. Review of the admission record for Resident #9 revealed she was a long term resident of the facility since 2022 and resided on the secured unit at the time of the social media postings. Resident #9's diagnoses included unspecified without behavioral disturbance, disturbance, disturbance , and	N 203		

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	65320C	A. BUILDING: _____ B. WING _____	C 02/28/2025

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N 203	Continued From page 25 . A significant change MDS was completed on with a score of 00, indicating severe . Review of Resident #9's record revealed no documentation of consent for social media video postings. A call was placed to Resident #9's FM on at 1:48 p.m. with no answer received. A voicemail was left, but no return call was received. Review of the admission record for Resident #16 revealed she resided in the facility's secured unit since 2023 with diagnoses to include , disturbance, disturbance and . A physician attestation of incapacity form dated showed the resident was unable to communicate a willful and knowing health decision. A quarterly MDS assessment was completed with a score of 10, indicating moderate . Review of Resident #16's record revealed no documentation of consent for social media video postings. Review of the admission record for Resident #11 revealed he resided in the facility's secured unit since 2023 with diagnoses to include unspecified without behavioral disturbance, major disturbance, disturbance and . A physician attestation of incapacity form dated showed the resident was unable to communicate a willful and knowing health decision. A quarterly MDS assessment was completed with a score of 6, indicating severe . Review of Resident #11's record revealed no documentation of consent for social media video postings. An interview was conducted with the Nursing Home Administrator (NHA) and Regional Nurse	N 203		

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N 203	Continued From page 26 Consultant (RNC) on at 12:50 p.m. The RNC stated she saw a sports reel come across her social media webpage a couple of weeks ago and recognized the facility and Staff I, Admissions Coordinator. The RNC reported informing the NHA. The NHA stated she found videos of the residents posted on a social media platform by Staff I, Admissions Coordinator. The NHA identified Resident #8 and Resident #10 in the videos. The NHA had no knowledge of these videos being posted, and no staff had informed her. The NHA reported staff may have thought Staff I, Admissions Coordinator was filming for activities. The NHA was unaware of other residents posted on social media sites until identified on . The NHA stated Staff I was suspended and would be terminated on . Video and photographic evidence was obtained. CLASS III	N 203		
N 917 SS=D	400.147(8), FS Report , Neglect, & . (8) , neglect, or , must be reported to the agency as required by 42 C.F.R. s. 483.13(c) and to the department as required by chapters 39 and 415. This Statute or Rule is not met as evidenced by: Based on interview and policy review the facility failed to ensure an allegations of neglect were reported related to a with major injury due to the facility's failure to ensure a safe environment, free from flooring hazards for one resident (#6) of 19 ambulatory residents in the facility's memory	N 917	1. Immediate action(s) taken for the resident(s) found to have been affected include: Nursing Home Administrator/ Coordinator re-educated on ensuring that allegations of , neglect, , ,	

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N 917	Continued From page 27 care unit. Findings included: Review of the policy - , Neglect, and , , reviewed , revealed "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent , neglect, , and misappropriation of the resident property." The policy defined "Serious Bodily Injury" as "an injury involving extreme physical , ; Involving substantial risk of ; Involving protracted loss or , of the function of a bodily member, organ, or mental faculty; requiring medical interventions such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal ". Neglect was defined as "failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, , mental anguish, or emotional distress." The policy revealed the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: (a.) Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involved or result in a serious bodily injury. Review of a progress note dated at 12:43 p.m. revealed the resident had an unwitnessed in the hallway "this A.M.". Resident (#6) was observed lying on right side and crying out in , to lower and right .	N 917	or mistreatment are reported according to federal guidelines time frame. Late report completed for Resident # 6. Resident #6 no longer resides at the facility. 2. Identification of other residents having the potential to be affected: Care Plan Coordinator/Designee completed quality review of residents who sustained in past 6 months. No newly affected residents identified. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: Education for all staff on , Neglect and , . A position has been created for a facility risk manager, and we are currently recruiting for the position. A daily Risk Management Meeting initiated at daily clinical meeting, to include attendance of the Interdisciplinary team with NHA oversight. Risk events including alleged violations involving possible , neglect, , , mistreatment, injuries of unknown source and misappropriation will be reviewed by Administrator/Risk Manager/Designee to ensure all reportable events meet the time frame guidelines for reporting. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Administrator/Risk Manager/Designee will conduct an audit of risk events to monitor all risk events for alleged violations including possible , neglect, , , mistreatment, injuries of unknown source and	

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N 917	Continued From page 28 On Resident #6 was ambulating in the hallway outside her room and suffered a significantly , _ the ability to walk and complete Activity of Daily Living (ADLs) independently. Resident #6 suffered a significant change due to a right requiring a surgical intervention. The which could have resulted in , caused Resident #6 permanent physical , . Review of the Reportable Event Log, dated , revealed events on and however neither of the reported incidents included Resident #6's with a major injury. During an interview with the Director of Nursing (DON) on at 2:15 p.m., the DON stated they did not report the incident because Resident #6's was not an adverse as the plan of care was followed. She reported the resident who had , was alert and , had poor safety awareness, was a long-term care resident residing in the memory care unit. Review of Resident #6's care plan initiated on showed a Focus -Resident #6 was at risk for related to history of , poor safety awareness, , , , , medication use and , . An intervention initiated on showed to "Ensure resident has a safe environment: (specify: even floors free from spills and/or clutter; adequate, glare- free light; a working and reachable call light, the bed in low position; rails on walls, personal items within reach)." Review of Resident #6's admission record revealed the resident was , , originally admitted to the facility on , with a recent	N 917	misappropriation and make certain violations are reported five times a week X 4 weeks, 3 times a week X 4 weeks, twice weekly X 4 weeks, then weekly and as indicated. Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.	

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N 917	Continued From page 29 hospital stay from to . The record showed diagnoses to include a displaced of base of of right subsequent encounter for closed with routine healing, aftercare following , replacement surgery, difficulty in walking, presence of right , , and and other classified elsewhere unspecified severity with agitation. A review of the Situation, Background, Appearance, and Review (SBAR) evaluation for Resident #6, dated , showed the resident tripped and in the hallway, complaining of lower and right , . The evaluation revealed new , in the right , lower and right , with an intensity score of 9 of 10. The documentation revealed the resident was left in place due to , on movement, and the primary physician placed an order to send the resident to the Emergency Room (ER) for evaluation on at 8:40 a.m. An interview was conducted on at 9:57 a.m. with Staff E, Licensed Practical Nurse, (LPN). Staff E stated she did not see the resident but "heard her scream". She stated the resident had suffered a change, "she does no walk anymore", "does a lot more crying", "doesn't eat as much as she used to". Review of the , report for Resident #6 on at 9:08 a.m., showed Resident #6 had undergone a right , , , . The post- , , results showed the , was "well-seated" with no evidence of hardware loosening or failure. During a facility tour on at 10:30 a.m. an area of rough and uneven concrete approximately 3ft ( ) x 2 ft in the middle of the corridor of the	N 917		

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N 917	Continued From page 30 200-hall located inside the memory care unit. The uneven concrete area had a drain cap located near the middle that was raised. The concrete area was a known high-traffic area, outside of the secured memory care dining room, the nurses' station, and just outside of Resident #6's room. Review of the "Completed" Work Order #13601 showed it was created on at 6:31 p.m. for a 200-hallway "clean out cover missing". The order asked, "please repair as soon as possible (asap)". "Please repair drain on 200 hallway asap". The update status on at 2:49 p.m. showed the Director of Maintenance (DOM) had noted the area "set to completed". On at 9:45 a.m. an interview was conducted with the DOM. He stated on 200-hall, the memory care unit, a resident had pulled the clean-out cap off on . The DOM reported "roping" the area off and cutting a metal piece to fit on top of the missing cap. He stated this was done after Resident #6 had . The DOM stated the facility had plumbers come in on . The DOM stated from to , he had put several patches on the area, and went every day to make sure it was secure and safe. The plumbers removed the tile all the way around the clean out cap, leaving a cemented patch. On at 2:04 p.m., the Regional DOM reported not being aware of the flooring issue. The Regional DOM stated depending on severity, if something could not be handled in-house the facility contacted vendors for repairs. The Regional DOM expected something to be implemented promptly, within one to two weeks for the safety of the residents.	N 917		

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N 917	Continued From page 31 An interview was conducted with the Director of Nursing (DON) on at 2:15 p.m. She stated Resident #6 had been ambulating in the hallway with a family member (FM) and her kind of got stuck on tape. The DON reported the FM grabbed the resident had pulled her, then the resident lost her balance and . The DON stated the resident had a history of , and because of right , , the resident was left on floor. The DON stated she interviewed Staff B/CNA, Staff C/CNA, and Staff E, Licensed Practical Nurse (LPN). The DON stated Staff E, LPN was sitting at the desk and did not witness the , but heard the resident call out and saw her lying on the right side. The DON confirmed Resident #6 suffered a , was transferred out to the hospital, had surgery and came to the facility. The DON stated Resident #6 had suffered a previous on . She stated the resident had a big chair in her room at the time so the family "decluttered" the room and when the resident started ambulating, the facility ensured the environment was free of clutter and slip hazards to prevent additional . An interview was conducted on at 12:00 p.m. with Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member described the area of concrete as similar to other drains on unit, showing a circular drain with a square metal outer plate. The staff member stated the residents on the unit like to pick at it and had pulled the square metal plate up. Staff J stated the facility had covered the area with an approximately same size metal square and had attached it to floor with yellow and black striped industrial tape so it would be recognized as a caution area. Staff J stated she doubted the residents in the memory care unit, with their ( ) scores, would	N 917		

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N 917	Continued From page 32	N 917		

have recognized it as a caution area. The staff member stated the concrete area was a high-traffic area as it was between the dining room, Resident #6's room, and the nursing station. She stated due to it being a unit, they had a lot of residents , up and down the hallways. She stated she could only report it to maintenance. Staff J stated the metal and tape were a hazard, and during the repair period the area had become bigger.

An interview was conducted on at 9:38 a.m. with the DON. She reported the findings of the Root Cause Analysis was the resident was ambulating in the hallway, she twisted, the family member took her arm, and her was caught on tape, causing the resident to . The DON stated she was not sure why the tape was on the floor.

On at 2:55 p.m. an interview was conducted with the NHA. She stated she did a QAPI (Quality Assurance Performance Improvement) on for . The NHA reported they initiated a PIP (Plan in Place) on due to there were 41 in , and one with . She stated she did not do QA (Quality analysis) on it.

Review of the Job Description for the Administrator, signed on showed the Position Purpose was "Leads, guides, and directs the operations of the health care facility in accordance with local, state, and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents." The Major Duties and Responsibilities included: Ensures resident incidents and concerns that rise to a reportable event such as alleged neglect,

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N 917	Continued From page 33 mistreatment, misappropriation, etc. (etcetera) are reported to the correct entity within the stated regulatory requirement. Review of the job description of Director of Nursing, signed by the DON on . The description showed the DON was to participate in daily or weekly management team meetings to discuss census changes, resident changes in status, complaints, or concerns. The description included: Monitors for allegations of potential or neglect, or misappropriation of resident property, and participates in the investigative process. Review of the policy - , Neglect, and , , reviewed , revealed "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent , neglect, , and misappropriation of the resident property." The policy defined "Serious Bodily Injury" as "an injury involving extreme physical , ; Involving substantial risk of ; Involving protracted loss or , of the function of a bodily member, organ, or mental faculty; requiring medical interventions such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal ". Neglect was defined as "failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, , , mental anguish, or emotional distress." The policy revealed the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within	N 917		

Agency for Health Care Administration

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N 917	Continued From page 34 specified timeframes: (a.) Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involved or result in a serious bodily injury. CLASS III.	N 917		

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F 000	INITIAL COMMENTS An unannounced complaint survey for complaint numbers 2024014135, 2024015562, 2024015980, 2025000650, 2025001182 and 2025002105 was conducted on through at Lakeland Nursing and Rehabilitation. The facility was not in compliance with Code for Federal Regulations (CFR), Part 483, Requirements for Long-Term Care Facilities. Findings of Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, , , or to a resident) related to complaint number 2025001182 were identified at: F689 and F921 Scope and Severity of "J" (Immediate Jeopardy to resident health or safety which is). The Immediate Jeopardy started on . The facility was informed of and provided the templates for F689 and F921 on at 4:03 p.m. for the Immediate Jeopardy. It was determined that the Immediate Jeopardy was removed on and the Scope and Severity for F689 and F921 was reduced to a "D" after verification of removal of immediacy of harm Substandard Quality of Care was identified at F689. A partial extended survey was completed on	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/2025

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.

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F 000	Continued From page 1	F 000		

The facility resident census at the beginning of the survey was 171.

Additional deficiencies were identified during the survey.

F 583 SS=F — Personal Privacy/Confidentiality of Records
CFR(s): 483.10(h)(1)-(3)(i)(ii)

§483.10(h) Privacy and Confidentiality.
The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

§483.10(h)(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as

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F 583	Continued From page 2 provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation of videos posted on social media platforms without consent, review of resident records, policy and procedures review, and staff, family and resident interviews, the facility did not ensure personal privacy and confidentiality for ten of sixteen sampled residents (#7, #8, #9, #10, #11, #12, #13, #14, #15, and #16). Findings Included: Review and observation of videos posted on social media platforms on , , , , , and additional dates that could not be determined showed Resident #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16 dancing or in the background of the videos, which also contained various staff members. These videos were recorded in various locations within the facility to include the secure memory care unit and hallways with room numbers where residents resided. Review of the social media videos showed they were originally posted by Staff I, Admissions Coordinator and had been reposted and edited by an unknown number of users on social media. Multiple videos were shown to share the first name of Resident #10 by Staff I, Admissions Coordinator, which was then included into other videos posted by unknown users across various social media platforms. A web	F 583	1. Immediate action(s) taken for the resident(s) found to have been affected include: Facility contacted residents□ responsible parties/representatives/families of residents #7, #8, #9, #10, #11, #12, #13, #14, #15, and #16 to notify them that the residents were posted on social media by a staff member, without the facility□s knowledge. Staff members were advised to remove all resident-related content from social media. All videos found were reported to the social media to remove videos. The legal department at Tik Tok was contacted to remove videos. Staff member was terminated. 2. Identification of other residents having the potential to be affected: Multiple social media platforms reviewed to identify any postings of facility residents. Facility-wide audit of all residents currently residing in the facility to verify photo consents are signed and present in the medical record. The photo consent form was revamped to include social media posting. The consent form does not permit staff to post on their personal pages. The consent clearly states for us on Lakeland Nursing and Rehab OPCO, LLCs official social media	

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F 583	Continued From page 3 browser search using Staff I's social media username showed videos containing Resident #10 with over 406,600 views, 70,600 likes, and 2,456 comments. The original videos were found to be removed; however, they could still be viewed under the search engine preview using Staff I's social media username. Review of the admission record for Resident #10 revealed she had resided in the facility since 2023 and lived in the secure memory care unit during the period the videos were posted. Resident #10's admission record included diagnoses of due to known physiological condition with mixed features, in other classified elsewhere-severe with disturbance, brief , major , - recurrent severe with , symptoms, and . Review of the annual minimum data set (MDS) assessment completed on showed a brief interview of mental status score ( ) score of 3, indicating severe . The quarterly MDS completed also showed a indicating severe . A phone interview was conducted with Resident #10's Family Member (FM) on at 2:31 p.m. The FM stated she was informed by facility administration around a week and a half ago about videos on [name of social media platform]. The FM reported receiving a call from an unknown nurse a week prior to that, telling her about the videos. The FM stated she would not have consented to Resident #10 being posted on social media and stated, "absolutely not." Review of the admission record for Resident #8 revealed she had resided in the facility since 2023 and lived in the secure unit during the period the	F 583	accounts. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: RDCS/DCS/Designee re-educated staff on facility policies to include , Neglect, , ; Resident Rights; Social Media; and Personal Cell Phone Use. NHA has since created an official social media page for authorized facility-related content and is the authorized administrator of the page. Resident records will be reviewed for photo and social media consent prior to any posting of content. No phones are allowed to be out in patient care areas. Nursing Home Administrator/Designee will search social media weekly for postings related to our facility. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The Admissions Director/Designee will conduct an audit of new admission records to make certain records contain Photo Consent Form five times a week X 4 weeks, 3 times a week X 4 weeks, twice weekly X 4 weeks, then weekly and PRN as indicated. The Administrator/Designee will conduct reviews of social media (Tik Tok, Facebook, Instagram) weekly x 8 weeks and every 2 weeks x 1 month, then monthly x 3 months and quarterly or PRN as indicated. Quality reviews will be completed once a week x8 weeks and then every 2 weeks	

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F 583	Continued From page 4 videos were posted. Resident #8's diagnoses included major -recurrent/moderate, due to known physiological condition with mixed features, , adult , unspecified -unspecified severity, with other behavioral disturbance, and . Review of the quarterly MDS assessment completed on showed a score of 00, indicating severe A phone interview was conducted with Resident #8's FM on at 2:19 p.m. She stated she was notified this week of videos being posted on social media, but did not know what social media pages. She was told it was just dancing. She stated no one had contacted her for consent prior to the posting of videos on social media. Review of the admission record for Resident #14 revealed he had resided in the facility since 2022 and lived in the secure unit during the period the videos were posted. Resident #8's diagnoses included , generalized , unspecified protein calorie due to known physiological condition, and in other classified elsewhere with disturbance. A determination of incapacity form was signed by the physician on . Review of the quarterly MDS assessments completed on and showed a score of 00, indicating severe A phone interview was conducted with Resident #14's Health Care Surrogate (HCS) on at 12:54 p.m. The HCS stated Resident #14 was unable to give consent due to and he did not give consent nor was he asked to provide consent for Resident #14 to be posted on social	F 583	x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.	

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media. He stated he was called this week and told that the videos were on the facility's social media page. He was not told the videos were posted on social media platforms and said he would not have given consent for that.

Review of the admission record for Resident #13 revealed she had resided in the facility since , of 2024 and lived in the secure unit when the videos were posted. Resident #13's diagnoses included unspecified , , disturbance, disturbance, and . A physician attestation of incapacity form dated showed the resident was , unable to communicate a willful and knowing health decision.
Review of a quarterly MDS, dated showed the resident had short term and long term memory problems and moderately , decision making skills.
A phone interview was conducted with Resident #13's FM on at 1:16 p.m. The FM stated the resident was lucid enough to discuss this matter with.
An interview was conducted with Resident #13 on at 1:43 p.m. She stated she had not been asked about being on social media postings and did not want to be included on postings. The resident said there was too much information out there, and she wanted to lay low.

Review of the admission record for Resident #7 revealed she had resided in the facility on the secured unit since early 2024. Resident #7's diagnoses included unspecified , , , brief, , , and major , . An incapacity statement was signed by the physician on , which showed the resident was

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incapable of exercising her rights to consent to medical and mental health treatment, to contract, and to make decisions about her social environment or other social aspects of her life. Resident #7's record showed indicated a court appointed guardian was in place. Review of an annual MDS assessment dated showed a score of 00, indicating severe . Review of Resident #7's record revealed no documentation that her legal guardian consented to the posting of the resident on social media.

Review of the admission record for Resident #12 revealed he had resided in the facility's secured unit since with diagnoses to include communication and major , A physician attestation of incapacity form dated showed the resident was unable to communicate a willful and knowing health decision. A significant change MDS assessment was completed with a score of 3, indicating severe .
A phone interview was conducted with Resident #12's FM on at 2:48 p.m.. The family member stated that did not consent to posting videos of the resident on social media. The FM reported she would have expected to be asked for consent prior to any postings on social media.

Review of the admission record for Resident #15 revealed she had resided in the facility's secured unit since 2023 with diagnoses to include unspecified with behavioral disturbance, , major , and , A physician attestation of incapacity form dated showed the resident was unable to communicate a willful

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F 583	Continued From page 7 and knowing health decision. Review of the last two quarterly MDS assessments completed and showed a score of 0, indicating severe . Review of Resident #15's record revealed no documentation of consent for social media video postings. Interview with Resident #15's FM on at 11:40 a.m. confirmed he did not provide consent but did not express concerns. Review of the admission record for Resident #9 revealed she was a long term resident of the facility since 2022 and resided on the secured unit at the time of the social media postings. Resident #9's diagnoses included unspecified without behavioral disturbance, disturbance, disturbance , and . A significant change MDS was completed on with a score of 00, indicating severe . Review of Resident #9's record revealed no documentation of consent for social media video postings. A call was placed to Resident #9's FM on at 1:48 p.m. with no answer received. A voicemail was left, but no return call was received. Review of the admission record for Resident #16 revealed she resided in the facility's secured unit since 2023 with diagnoses to include , disturbance, disturbance and . A physician attestation of incapacity form dated showed the resident was unable to communicate a willful and knowing health decision. A quarterly MDS assessment was completed with a score of 10, indicating moderate . Review of Resident #16's record revealed no documentation of consent for social	F 583		

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F 583	Continued From page 8 media video postings. Review of the admission record for Resident #11 revealed he resided in the facility's secured unit since 2023 with diagnoses to include unspecified without behavioral disturbance, major disturbance, disturbance and . A physician attestation of incapacity form dated showed the resident was unable to communicate a willful and knowing health decision. A quarterly MDS assessment was completed with a score of 6, indicating severe . Review of Resident #11's record revealed no documentation of consent for social media video postings. An interview was conducted with the Nursing Home Administrator (NHA) and Regional Nurse Consultant (RNC) on at 12:50 p.m. The RNC stated she saw a sports reel come across her social media webpage a couple of weeks ago and recognized the facility and Staff I, Admissions Coordinator. The RNC reported informing the NHA. The NHA stated she found videos of the residents posted on a social media platform by Staff I, Admissions Coordinator. The NHA identified Resident #8 and Resident #10 in the videos. The NHA had no knowledge of these videos being posted, and no staff had informed her. The NHA reported staff may have thought Staff I, Admissions Coordinator was filming for activities. The NHA was unaware of other residents posted on social media sites until identified on . The NHA stated Staff I was suspended and would be terminated on	F 583		

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Review of the facility's policy titled Social Media Use, implemented and revised showed: "It is the policy of this company to avoid inappropriate use of social media and to protect the residents, staff, visitors, volunteers and practitioners of this facility against misuse of social media content. Taking, keeping, or distributing unauthorized photographs or recordings of residents through multimedia messages or on social media networks is a violation of a resident's right to privacy and confidentiality. Staff members must recognize that they have an ethical and legal ˛ to maintain resident privacy and confidentiality at all times.

Policy Explanation and Compliance guidelines:

1. Employees are strictly prohibited from transmitting by way of any electronic media any resident-related image or information that may be reasonably , to violate resident rights to confidentiality or privacy. This includes information that could degrade or embarrass the resident.

2. Photographs or recordings of a resident and/or his or her private space without the residents' or designated representatives; written consent, is prohibited. Examples include taking unauthorized photographs/videos of:

a. A resident's room or furnishings (which may or may not include the resident).

b. A resident eating in the dining room.

c. A resident participating in an activity in the common area.

d. Taking unauthorized photographs or recordings of residents in any state of dress or undress using any type of equipment.

3. Employees will not post or share posts that would disseminate any personal or medical record information regarding a resident. This

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F 583	Continued From page 10 would include medical, social, fund accounts, automated electronic or other types of personal resident information, as well as gender identity and orientation. 4. Employees will maintain professional boundaries in the use of social media. 5. Employees are not to share company data or information on social media. 6. Employees will refrain from making offensive remarks on social media about their employer, coworkers, visitors, volunteers or practitioners. This includes making threats, harassing, and using profane, obscene, , explicit, racially derogatory, or homophobic comments. 7. Employees will not post content or otherwise speak on behalf of the employer unless authorized to do so. Any employee who violates this policy may be subject to disciplinary action, up to and including termination." Video and photographic evidence was obtained.	F 583		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of , neglect, , , or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving , neglect, , or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve and do not result in serious bodily injury, to	F 609		

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F 609	Continued From page 11 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and policy review the facility failed to ensure an allegations of neglect were reported related to a with major injury due to the facility's failure to ensure a safe environment, free from flooring hazards for one resident (#6) of 19 ambulatory residents in the facility's memory care unit. Findings included: Review of a progress note dated at 12:43 p.m. revealed the resident had an unwitnessed in the hallway "this A.M.". Resident (#6) was observed lying on right side and crying out in , to lower and right . On Resident #6 was ambulating in the hallway outside her room and suffered a significantly , the ability to walk and complete Activity of Daily Living (ADLs) independently. Resident #6 suffered a significant	F 609	1. Immediate action(s) taken for the resident(s) found to have been affected include: Nursing Home Administrator/ Coordinator re-educated on ensuring that allegations of , neglect, , , or mistreatment are reported according to federal guidelines time frame. Late report completed for Resident # 6. Resident #6 no longer resides at the facility. 2. Identification of other residents having the potential to be affected: Care Plan Coordinator/Designee completed quality review of residents who sustained in past 6 months. No newly affected residents identified. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: Education for all staff on , Neglect and , . A position has been	

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change due to a right requiring a surgical intervention. The which could have resulted in , caused Resident #6 permanent physical , .

Review of the Reportable Event Log, dated , revealed events on and however neither of the reported incidents included Resident #6's with a major injury.

During an interview with the Director of Nursing (DON) on at 2:15 p.m., the DON stated they did not report the incident because Resident #6's was not an adverse as the plan of care was followed. She reported the resident who had , was alert and , had poor safety awareness, was a long-term care resident residing in the memory care unit.

Review of Resident #6's care plan initiated on showed a Focus -Resident #6 was at risk for related to history of , poor safety awareness, , , , , medication use and , , . An intervention initiated on showed to "Ensure resident has a safe environment: (specify: even floors free from spills and/or clutter; adequate, glare- free light; a working and reachable call light, the bed in low position; rails on walls, personal items within reach)."

Review of Resident #6's admission record revealed the resident was , , originally admitted to the facility on , with a recent hospital stay from to . The record showed diagnoses to include a displaced of base of of right subsequent encounter for closed with routine healing, aftercare following , replacement surgery,

created for a facility risk manager, and we are currently recruiting for the position. A daily Risk Management Meeting initiated at daily clinical meeting, to include attendance of the Interdisciplinary team with NHA oversight. Risk events including alleged violations involving possible , neglect, , , mistreatment, injuries of unknown source and misappropriation will be reviewed by Administrator/Risk Manager/Designee to ensure all reportable events meet the time frame guidelines for reporting.

4. How the corrective action(s) will be monitored to ensure the practice will not reoccur:
The Administrator/Risk Manager/Designee will conduct an audit of risk events to monitor all risk events for alleged violations including possible , neglect, , , mistreatment, injuries of unknown source and misappropriation and make certain violations are reported five times a week X 4 weeks, 3 times a week X 4 weeks, twice weekly X 4 weeks, then weekly and as indicated. Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.

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difficulty in walking, presence of right , , , and and other classified elsewhere unspecified severity with agitation.

A review of the Situation, Background, Appearance, and Review (SBAR) evaluation for Resident #6, dated , showed the resident tripped and in the hallway, complaining of lower and right . The evaluation revealed new , in the right , lower and right with an intensity score of 9 of 10. The documentation revealed the resident was left in place due to , on movement, and the primary physician placed an order to send the resident to the Emergency Room (ER) for evaluation on at 8:40 a.m.

An interview was conducted on at 9:57 a.m. with Staff E, Licensed Practical Nurse, (LPN). Staff E stated she did not see the resident but "heard her scream". She stated the resident had suffered a change, "she does no walk anymore", "does a lot more crying", "doesn't eat as much as she used to".

Review of the , report for Resident #6 on at 9:08 a.m., showed Resident #6 had undergone a right , , , . The post- , , results showed the , was "well-seated" with no evidence of hardware loosening or failure.

During a facility tour on at 10:30 a.m. an area of rough and uneven concrete approximately 3ft ( ) x 2 ft in the middle of the corridor of the 200-hall located inside the memory care unit. The uneven concrete area had a drain cap located near the middle that was raised. The concrete area was a known high-traffic area, outside of the

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secured memory care dining room, the nurses' station, and just outside of Resident #6's room.

Review of the "Completed" Work Order #13601 showed it was created on at 6:31 p.m. for a 200-hallway "clean out cover missing". The order asked, "please repair as soon as possible (asap)". "Please repair drain on 200 hallway asap". The update status on at 2:49 p.m. showed the Director of Maintenance (DOM) had noted the area "set to completed".

On at 9:45 a.m. an interview was conducted with the DOM. He stated on 200-hall, the memory care unit, a resident had pulled the clean-out cap off on . The DOM reported "roping" the area off and cutting a metal piece to fit on top of the missing cap. He stated this was done after Resident #6 had . The DOM stated the facility had plumbers come in on . The DOM stated from to , he had put several patches on the area, and went every day to make sure it was secure and safe. The plumbers removed the tile all the way around the clean out cap, leaving a cemented patch.

On at 2:04 p.m., the Regional DOM reported not being aware of the flooring issue. The Regional DOM stated depending on severity, if something could not be handled in-house the facility contacted vendors for repairs. The Regional DOM expected something to be implemented promptly, within one to two weeks for the safety of the residents.

An interview was conducted with the Director of Nursing (DON) on at 2:15 p.m. She stated Resident #6 had been ambulating in the

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hallway with a family member (FM) and her kind of got stuck on tape. The DON reported the FM grabbed the resident had pulled her, then the resident lost her balance and . The DON stated the resident had a history of , and because of right , , the resident was left on floor. The DON stated she interviewed Staff B/CNA, Staff C/CNA, and Staff E, Licensed Practical Nurse (LPN). The DON stated Staff E, LPN was sitting at the desk and did not witness the , but heard the resident call out and saw her lying on the right side. The DON confirmed Resident #6 suffered a , was transferred out to the hospital, had surgery and came to the facility. The DON stated Resident #6 had suffered a previous on . She stated the resident had a big chair in her room at the time so the family "decluttered" the room and when the resident started ambulating, the facility ensured the environment was free of clutter and slip hazards to prevent additional .

An interview was conducted on at 12:00 p.m. with Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member described the area of concrete as similar to other drains on unit, showing a circular drain with a square metal outer plate. The staff member stated the residents on the unit like to pick at it and had pulled the square metal plate up. Staff J stated the facility had covered the area with an approximately same size metal square and had attached it to floor with yellow and black striped industrial tape so it would be recognized as a caution area. Staff J stated she doubted the residents in the memory care unit, with their ( ) scores, would have recognized it as a caution area. The staff member stated the concrete area was a

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high-traffic area as it was between the dining room, Resident #6's room, and the nursing station. She stated due to it being a unit, they had a lot of residents _ up and down the hallways. She stated she could only report it to maintenance. Staff J stated the metal and tape were a hazard, and during the repair period the area had become bigger.

An interview was conducted on at 9:38 a.m. with the DON. She reported the findings of the Root Cause Analysis was the resident was ambulating in the hallway, she twisted, the family member took her arm, and her was caught on tape, causing the resident to . The DON stated she was not sure why the tape was on the floor.

On at 2:55 p.m. an interview was conducted with the NHA. She stated she did a QAPI (Quality Assurance Performance Improvement) on for . The NHA reported they initiated a PIP (Plan in Place) on due to there were 41 in , and one with . She stated she did not do QA (Quality analysis) on it.

Review of the Job Description for the Administrator, signed on showed the Position Purpose was "Leads, guides, and directs the operations of the health care facility in accordance with local, state, and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents." The Major Duties and Responsibilities included: Ensures resident incidents and concerns that rise to a reportable event such as alleged neglect, mistreatment, misappropriation, etc. (etcetera)

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are reported to the correct entity within the stated regulatory requirement.

Review of the job description of Director of Nursing, signed by the DON on . The description showed the DON was to participate in daily or weekly management team meetings to discuss census changes, resident changes in status, complaints, or concerns. The description included: Monitors for allegations of potential or neglect, or misappropriation of resident property, and participates in the investigative process.

Review of the policy - , Neglect, and , reviewed , revealed "It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent , neglect, , and misappropriation of the resident property." The policy defined "Serious Bodily Injury" as "an injury involving extreme physical , ; Involving substantial risk of ; Involving protracted loss or , of the function of a bodily member, organ, or mental faculty; requiring medical interventions such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal ". Neglect was defined as "failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, , , mental anguish, or emotional distress." The policy revealed the facility will have written procedures that include: reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g., law enforcement when applicable) within

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F 609	Continued From page 18 specified timeframes: (a.) Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involved or result in a serious bodily injury.	F 609		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Cross Reference F921 Based on observations, interviews, and record review, the facility failed to provide supervision and failed to prevent accident hazards to prevent a with injury for one resident (#6) of 19 ambulatory residents in the memory care unit. The facility failed to replace a clean-out drain located in a high traffic area of the facility's memory care unit and failed to promptly and effectively address flooring issues, resulting in an unsafe walkway, where Resident #6 tripped and . On , Resident #6 was ambulating in the hallway outside her room and suffered a significantly , the ability to walk independently and complete Activities of Daily Living (ADLs) at her prior functional level. The resident suffered a significant change due to a right requiring a surgical	F 689	Immediate action(s) taken for the resident(s) found to have been affected include: Flooring was repaired to prevent further accidents. Resident # 6 is no longer resides in the facility. 2. Identification of other residents having the potential to be affected: NHA and Director of Maintenance performed rounds of the facility to identify any hazardous areas. Identified hazards removed and/or repaired. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: DCS/Designee provided education on Accidents and Supervision policy, redirecting residents with from environmental hazards, and recognizing and reporting potential environmental hazards. An additional staff	

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F 689	Continued From page 19 intervention of a right , , . The facility's failure to provide supervision and prevent accident hazards caused serious harm and injuries to Resident #6 and placed 18 additional ambulatory residents in the memory care unit at risk for serious injury, harm, and/or . This failure resulted in the determination of Immediate Jeopardy on . The findings of Immediate Jeopardy were determined to be removed on and the severity and scope was reduced to a "D." Findings included: A review of Resident #6's admission record revealed the resident was , , originally admitted to the facility on , with a recent hospital stay from to . The record showed diagnoses to include a displaced of base of of right subsequent encounter for closed with routine healing, aftercare following , replacement surgery, difficulty in walking, presence of right , , , and and other classified elsewhere unspecified severity with agitation. A review of the Situation, Background, Appearance, and Review (SBAR) Communication Form and Progress Note revealed Resident #6 had a change in condition of a on . The Situation section of the form documented "status post , trip and in hallway, complaining of lower and right , ." The Background section documented the resident has new , with an intensity of 9 out of 10 (10 being the worst). The Appearance section documented "status post in hallway, left in place due to , on movement. 911 called." The	F 689	member has been assigned to memory care unit as Hall Monitor to increase supervision. 4. How the corrective action(s) will be monitored to ensure the practice will not reoccur: Administrator/Director of Maintenance/Designee will complete facility assessment rounds to make certain facility is free of hazards once weekly x 8 weeks; then every w weekly x 4 weeks and will continue weekly rounds ongoing. Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.	

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Review and Notify section documented that the primary care clinician was notified on at 8:40 a.m. with recommendations to send to the Emergency Room (ER) for evaluation. The Family Member (FM) was notified on at 8:44 a.m.

A review of Resident #6's hospital History and Physical Report, dated at 12:59 p.m. revealed this female had a medical history of , dyslipidemia, and [ ]. The nursing home resident, presented to the hospital from the nursing home after a . The patient was found on the ground and complaining of right . The patient's baseline was , and she could only recognize her [FM]. The completed , imaging studies, on at 10:44 a.m. showed a right . The Computed Scan (CT) of the without contrast, on at 10:04 a.m., revealed " right with angulation and mild displacement." The results of the right and right , with showed "normal ."

A review of a hospital consultation note dated at 6:04 p.m. showed the resident was complaining of right and the physical examination showed the right lower extremity was shortened and externally rotated. The assessment/plan showed resident "would benefit from intervention of the right , in order to provide stability to the and promote satisfactory healing, to improve , to facilitate early motion and mobilization and to prevent complications associated with prolonged bedrest." The risks, benefits, complications, and alternatives treatments were explained to the patient and FM. This included "the possibilities of

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, , , reaction to , compromise, or dying on the table, incomplete relief of symptoms, and or stiffness."
A review of the , report on at 9:08 a.m., showed Resident #6 had undergone a right , , . The post- , results showed the , was "well-seated" with no evidence of hardware loosening or failure.
A review of Resident #6's clinical record at the facility prior to the with a revealed a quarterly Minimum Data Set (MDS), dated . The pattern (Section C) showed a Brief Interview of Mental Status ( ) score of 9, indicating moderate , . The functional abilities assessment (Section GG) revealed the resident was independent with eating, oral and toileting hygiene, and upper/lower body . The resident required supervision with shower/bathing self, putting on/taking off footwear, and personal hygiene. The resident was independent with rolling left to right, sitting to lying, lying to sitting, sit to stand, transferring from chair/bed-to-chair, toilet transferring, walking 10 and walking 50 with two turns. The resident required partial assistance with tub/shower transfer, and supervision with walking 150 . The resident was always of and frequently of (Section H). The health conditions assessment (Section J) revealed the resident had no , 5 days prior to the assessment, and had not since admission/entry, reentry, or prior assessment.
A review of Resident #6's last , , ( ) Discharge Summary (prior to the with a) was dated and showed the resident was able to ambulate with no

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assistive device with modified independence ( ) for up to 300 ft. or as tolerated on level surface with verbal cues for directional changes.
A review of Resident #6's last Risk Evaluation (prior to the with a) was dated for a last known on with a risk score of 9 (a score of 8 or higher indicates a risk).
A review of a facility note dated at 5:30 p.m., showed Resident #6 returned to the facility from the hospital following a right , , (related to the on).
The record showed the resident was in , whenever touched. The resident had a surgical on the right .
A review of a Risk Evaluation conducted on at 5:39 p.m. showed the last known was on . The resident's risk score was 17.
A review of a Evaluation dated showed Resident #6's prior level of function (PLOF) for bed mobility and transfers was independent with a baseline on of total assistance. The PLOF for walking was supervision with rolling walker up to 200 with a baseline on of unable.
A review of Resident #6's 5-day MDS (post and hospitalization), dated , revealed the resident had a score of 00, indicating severe , . The functional abilities assessment showed the resident was dependent on eating, oral and toileting hygiene, shower/bathing, upper/lower body , and putting on/taking off footwear. The resident was dependent for rolling left to right, sitting to lying, lying to sitting, sit to stand, transferring from chair/bed-to-chair, toilet transferring, car transferring, walking 10 , walking 50 with two turns, and walking 150 . The assessment

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showed the resident was using a manual wheelchair. The resident was of and . The health conditions revealed frequent , , no in the last month prior to admission/entry or reentry, no related to a in the 6 months prior to admission/entry or reentry and had major surgery during the 100 days prior to admission.

A review of Resident #6's care plan initiated on and revised on revealed the resident was at risk for related to history of , poor safety awareness, , , , , medication use, and , .

The interventions for the care plan included:
Ensure resident has a safe environment: (Specify: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position; handrails on walls, personal items within reach) initiated on .

Keep environment/walkway free of trip hazards initiated on and revised on .

Family to assist with decluttering room for safety initiated on and revised on .

Scoop mattress initiated on .

During a facility tour on at 10:30 a.m. an area of rough and uneven concrete approximately 3ft ( ) x 2 ft in the middle of the corridor of the 200-hall located inside the memory care unit. The uneven concrete area had a drain cap located near the middle that was raised. The concrete area was a known high-traffic area, outside of the secured memory care dining room, the nurses' station, and just outside of Resident #6's room.

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F 689	Continued From page 24 A review of an electronic work order created on at 6:31 p.m. by Staff G, Licensed Practical Nurse (LPN) revealed "clean out cover missing," location 200 hallway, priority level medium, and a note/comment to "repair drain on 200 hallway asap [as soon as possible]." The status of the order was updated by the Director of Maintenance (DOM) on at 2:49 p.m. as "Set to Completed." A Room Audit Form, for "Project Clean OUT 200 Hall" with a start date of revealed daily notes monitoring the clean out cover area from to documented by the DOM. The first entry on the log, dated , showed the (DOM) placed a metal sheet cover over the drain opening with tape. The entry on , the day the work order status was updated, showed a visual inspection was done in the morning and fresh tape was applied that evening. None of the entries between and showed any additional work outside of visual inspection and applications of fresh tape was completed. A review of the audit log revealed no documentation to show the area was visually inspected to ensure safety of residents, staff, and visitors on , , , , , , , , , , , , , and . The log showed on "morning - Resident [#6] , fresh tape -plumber called -Received Quote & Sent." The log showed on "evening - Job completed." A review of an email dated confirmed the plumbing company had completed a repair of the area on the 200 hall on , 4 days after Resident #6 and 37 days after the original work order was created. An interview on at 1:34 p.m. with Staff C, Certified Nursing Assistant (CNA) revealed she	F 689		

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witnessed Resident #6's incident on . Staff C, CNA reported Resident #6 was in the hallway with her FM. The resident was attempting to detach herself from tape on the floor in the unrepaired plumbing area that was covered with concrete. The staff member stated the tape was not holding anything down. Staff C saw Resident #6 lose her balance and . Review of a written statement by Staff C, CNA dated at 8:30 a.m. showed Staff C was coming down the hall with a breakfast tray and witnessed Resident #6 trip and over an area on the floor. The tape was coming up and Resident #6's got caught on it.

On at 9:45 a.m., an interview was conducted with the DOM. He stated on 200-hall, the memory care unit, a resident had pulled the clean-out cap off, on . The DOM reported "roping" the area off and cutting a metal piece to fit on top of the missing cap. He stated this was done after Resident #6 had . The DOM stated the facility had plumbers come in on . The DOM stated from to , he had put several patches on the area, and went every day to make sure it was secure and safe. The DOM reported the plumbers removed the tile all the way around the clean out cap, leaving a cemented patch.
On at 10:46 a.m., the DOM observed the 200 hall and showed the area where Resident #6 had in the hallway. The area was near the nursing station in the 200-hall and just outside of Resident 6's room at that time of the incident. The DOM observed an additional area of missing floor tiles on the 200 hall and stated the facility had just received the diamond blades to smooth out the concrete. He stated the plumbers had to remove the tiles to fix a plumbing issue.

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During the time of this interview, the DOM confirmed the area where Resident #6 had was still uneven due to the concrete patch left by the plumbers on .
A follow-up interview on beginning at 3:05 p.m. with the DOM revealed the rough concrete patch observed during the survey beginning on was part of the repair. The DOM stated he had to research a replacement cap since the missing cover was so old. The DOM stated the plumber did not have a cap to fit the iron piping, so the plumber had to make the hole bigger and cut pipe to fix it. The DOM revealed this repair happened in the middle of . The DOM stated he had put a metal plate on the area trying to save the company money in . The DOM reported he was researching it to try to fix it himself before calling the plumbers in, but after Resident #6's , he was done searching for the replacement and decided to get plumbers in. The DOM stated he felt the location where Resident #6 was safe and felt the [brand name] tape was a good tape to use as a temporary fix. The DOM reported the diamond grinding wheel, needed to smooth out concrete, had been ordered and came in "last week." The DOM said he had looked at local merchants for the grinding wheel, but they did not have the size needed in stock. The DOM stated the diamond wheel was delivered on , the day before he went on vacation. Review of the online merchant's receipt for the 4.5-inch diamond concrete grinding wheel showed the order was placed on and shipped on . At the time of this interview, the area where Resident #6 was still not fully repaired leaving a rough and uneven flooring surface in this high traffic area.

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During an interview on at 2:15 p.m., the Director of Nursing (DON) stated Resident #6 had been ambulating in the hallway with a family member and her kind of got stuck on tape. The DON reported the FM grabbed the resident had pulled her, then the resident lost her balance and . The DON stated the resident had a history of , and because of right , , the resident was left on floor. The DON stated she interviewed Staff B/CNA, Staff C/CNA, and Staff E, Licensed Practical Nurse (LPN). The DON stated Staff E, LPN was sitting at the desk and did not witness the , but heard the resident call out and saw her lying on the right side. The DON confirmed Resident #6 suffered a , was transferred out to the hospital, had surgery and came to the facility. The DON stated Resident #6 had suffered a previous on . She stated the resident had a big chair in her room at the time so the family "decluttered" the room and when the resident started ambulating, the facility ensured the environment was free of clutter and slip hazards to prevent additional .

An interview was conducted on at 12:00 p.m. with Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member described the area of concrete as similar to other drains on unit, showing a circular drain with a square metal outer plate. Staff J, LPN/UM stated the residents on the unit like to pick at it and had pulled the square metal plate up. Staff J, LPN/UM stated maintenance had covered the area with a metal square that was approximately the same size as the missing plate and secured it to the floor with yellow and black striped industrial tape so it would be recognized as a caution area. Staff J, LPN/UM stated she doubted the residents in the memory

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care unit would have recognized the tape as a caution area. The staff member stated the concrete area was a high-traffic area as it was between the dining room, Resident #6's room, and the nursing station on the memory care unit. Staff J, LPN/UM stated they had a lot of residents up and down the hallways due to on the unit. Staff J, LPN/UM said she could only report it to maintenance, and then it was out of her . Staff J, LPN/UM stated the metal and tape was a hazard, and during the repair period, the area had become larger in size.

A review of a work order dated at 2:24 p.m. showed Staff J, LPN/UM reported missing tile on the floor of the 200 hallway with a medium priority level. The work order was acknowledged by the DOM on at 3:30 p.m. with a status of "Set to-In-Progress." The work order was updated on at 2:17 p.m. by the DOM with a status of "Set to completed."

On at 10:18 a.m., a second area in hall 200 towards the front of the facility, near the janitor supply closet #3 was observed with 12 missing tiles. The area was in the walking path of residents in the memory care unit. The area had a raised drain with a cap near the middle of it. An immediate interview was conducted with Staff B, Certified Nursing Assistant (CNA) who confirmed the area had been in disrepair for a "long time" and estimated it to be approximately 6 to 8 months.

On at 10:38 a.m., the entrance ramp to the 400-hall was observed missing five full carpet squares (approximately 2 ft x 2 ft) and 5 half carpet squares leaving exposed concrete with a raised drain that was not level to the concrete,

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and the carpet that remained was not level with the concrete. A yellow traffic cone was placed in the corner from the hallway to the ramp. This area was the inside entrance for residents, staff and visitors to access the 400-hall and used frequently by residents with ambulation devices and wheelchairs.

On at 2:04 p.m., the Regional DOM reported not being aware of the flooring issue. The Regional DOM stated depending on severity, if something could not be handled in-house the facility contacted vendors for repairs. The Regional DOM expected something to be implemented promptly, within one to two weeks for the safety of the residents.

During a facility tour of the 200 hall on at 2:21 p.m. with the Nursing Home Administrator (NHA), revealed tiles that were popping up on the edges where the facility had replaced flooring using old tiles. The NHA confirmed the area was a hazard for someone with a shuffling gait. The NHA stated the tiles needed to be put down again and better. The NHA stated her expectation was an immediate fix for any hazard affecting residents. The NHA observed the area where Resident #6 and stated she expected the area to be safe for the residents. The NHA stated it was unacceptable to wait to repair the floors.

Photographic evidence was obtained.

Review of the Prevention Program, implemented on , revealed "Each resident will be assessed for risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of ." The policy defined a " " as

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an event in which an individual unintentionally comes to rest on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). The event may be witnessed, reported, or presumed when a resident is found on the floor or ground, and can occur anywhere."
The policy explanation and compliance guidelines showed the facility utilized a standardized risk assessment for determining a resident's risk. Low/moderate risk protocols include implementation of universal environmental interventions that decrease the risk of a resident falling, including, but not limited to: A clear pathway to the bathroom and bedroom doors.

A review of the facility's immediate actions to remove the Immediate Jeopardy included:
1. Immediate Action:
Environmental rounds completed, identified areas of concern noted.
Summoned Corporate Plant Operations support team for assistance.
Quality review completed for all current residents sustaining a to ensure plan of care is in place in the past 6 months, no discrepancies noted.
Medical Record Review of all residents with with major injury in the past 6 months conducted; no discrepancies noted.
99.5% of all facility staff were educated by 9:00 a.m. on .
Initiated and assigned direct care staff member as "Hallway Safety Monitor" on secure unit (200 Hall) for additional supervision. Hallway Safety Monitor will be assigned for 24 hours a day X 7 days to establish a pattern of ambulatory residents. When pattern is established, Hallway Safety Monitor will be staffed from 0700 to 2300 daily X 14 days. Then, as pattern is further

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established, Hallway Safety Monitor will be staffed 12 hours daily X 30 days. Hallway Safety Monitor staffing hours will be adjusted as indicated.
2. Identification of others at risk was accomplished by:
On - The Director of Clinical Services (DCS) and designee(s) reassessed all residents residing in the facility for risk via Risk Evaluation.
Facility implemented Activities Invitation Rounds for residents identified at risk for . Activities staff will encourage identified residents to attend activities of choice and document on log to establish a pattern of attendance/ preferences.
The Care Plan Coordinator(s) completed review of care plans to ensure all residents identified as "at risk" for (Risk Score of 8 or higher) had safety measures, as well as resident specific interventions in place and to ensure the safety measures and resident specific interventions are also reflected on the Kardex so that the CNA's have access to this information.
Quality review completed for monitoring of environmental hazards with a focus on uneven surfaces and hazards.
Identified environmental concerns addressed by priority level, initiated repairs and ongoing.
Record review of Resident #6 completed. , , screen completed on ; / services ongoing. Resident seen by psych provider. No changes in or mentation noted. Management in place. Resident has orders for pharmacological , intervention: , External Patch, and as of . Resident was previously on Norco, but medication was discontinued.
3.Actions to Prevent Occurrence/Recurrence:
NHA, DCS, and Plant Operations/Maintenance Director re-educated on ensuring resident

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environment is free of hazards with emphasis on timely completion.
Regional DCS educated the DCS on the facility's Prevention Program, all facility related policies, how to conduct an RCA, and how to ensure incident investigations are timely and complete.
DCS/designee re-educated staff on facility Prevention Program guidelines, following care plan/Kardex interventions, as well as all facility related policies.
DCS/Designee re-educated staff on , Neglect, , Policy.
DCS/Designee re-educated staff on Residents' Rights.
DCS/Designee re-educated staff on Accidents and Supervision Policy.
DCS/Designee re-educated staff on Recognizing & Reporting Hazards.
DCS/Designee re-educated staff on Redirecting Residents with from Environmental Hazards
DCS/Designee re-educated staff on securing hazardous areas until plant ops clears, ensuring no harm.
The Director of Clinical Services/designee to conduct quality monitoring of new admission risk evaluation completion to ensure that risk factors, safety measures, and resident specific interventions are reflected on the care plan and Kardex five times weekly x 8 weeks, three times weekly x 2 weeks; twice weekly x 2 weeks, then weekly and PRN (as needed) as indicated.
A Performance Improvement Plan (PIP) has been initiated to report on the above monitoring and auditing procedures. All finding from the PIP will be presented at the monthly Quality Assessment & Assurance (QAA) meeting. Monitoring/auditing and reporting will continue for a minimum of three

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months.
4. NHA/Plant Ops/Designee will round to ensure facility is free of hazards daily X 7 days, then daily X 5 days, then twice weekly x 8 weeks; then weekly and PRN as indicated. DON/designee will review all at the clinical meeting with the IDT (interdisciplinary) daily X 5 (Business Days) for 4 weeks to ensure appropriate interventions are implemented, the resident's care plan has been reviewed and revised, and the Kardex has been update; then 3 x weekly X 4, then twice weekly x 4, then weekly x 4, then monthly x 3; and PRN as indicated. Regional DCS will review weekly for three months to ensure a RCA (root cause analysis) has been conducted and that resident specific interventions are reflected in the care plan as well as updated on the Kardex. These audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the assigned auditors for three months.

Verification of the facility's removal plan was conducted by the survey team on .

On observations were made to ensure the facility repaired the concrete area in the 200-hall to include level tiles and repaired the area at the end of the 200-hall to ensure the tiled area was level. The facility removed the carpet on the 400-ramp and replaced it with two pieces of rolled carpet. The facility educated 99% of their staff on notifying supervisors of accident hazards and to notify other management if the hazard was not repaired.

Interviews were conducted with 77 staff members, which included the NHA, the DOM, 13 licensed nurses, 17 CNAs, and 45 other staff members across all shifts. The staff members

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F 689	Continued From page 34 were able to state that they had been trained and were knowledgeable about the new procedures. Interview with the NHA on revealed a couple of the staff were not reachable, but a system was put into place for education prior to their next working day. Based on verification of the facility's Immediate Jeopardy removal plan the immediate jeopardy was determined to be removed on and the non-compliance was reduced to a scope and severity of "D."	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and ( ) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
( ) For public health activities, reporting of , neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 36 (vi) Laboratory, and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure documentation was accurate and complete for one (#4) of one resident related to the documentation of a change in condition resulting in being administered. Findings included: Review of Resident #4's Admission Record revealed the resident was most recently admitted to the facility on . The record included diagnoses of idiopathic , acute , failure with , unspecified , unspecified , and dependence on supplemental . Review of Resident #4's clinical record showed a Hospital Transfer Form, dated at 1:40 p.m. showed the resident was a Full Code. Review of a Situation, Background, Appearance, and Review/Notify (SBAR) assessment dated at 9:37 a.m. showed notification to the provider of resident change in condition related to food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts). Review of Resident #4's progress note, dated at 1:56 p.m. showed the resident was transferred from one room to another at 1:30 p.m., and the resident was found unresponsive. Emergency Medical Transport (EMT) was called, and the physician and family were notified.	F 842	1. Immediate action(s) taken for the resident(s) found to have been affected include: Review of resident #4s clinical record. Resident #4 was transferred out to Lakeland Regional Medical Center. Upon record review resident #4 was transferred out and expired, therefore, she no longer resides at Lakeland Nursing and Rehab. Late entry regarding the event was input in Resident #4s clinical record. 2. Identification of other residents having the potential to be affected: Quality review of code blue events to ensure record contains documentation of per advance directive order. Review of code blue events for the past 90 days to ensure change of condition, transfer forms, if applicable, MD notification, and resident representative notification. 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: Director of Clinical Services reeducated on documentation policy. All licensed nurses educated on proper documentation protocols, code blue events, change of condition and transfer forms. Code blue events, change of conditions, and transfer forms will be reviewed in the morning clinical meeting with follow-up as necessary. 4. How the corrective action(s) will be monitored to ensure the practice will not	

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F 842	Continued From page 37 An interview was conducted on at 3:22 p.m. with the Director of Nursing (DON). The DON reported Resident #4 was transferred on , and stated the resident had initiated in the facility, and the physician present in the facility assisted. She stated the expectation was for staff to document was initiated and EMT was called in the clinical record. A follow-up interview with the DON on at 3:58 p.m. confirmed the clinical record and transfer form did not reveal the resident had received . Review of the policy - Documentation in Medical Record, implemented , showed "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation." The compliance guidelines included: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3c. Documentation shall be timely and in chronological order.	F 842	reoccur: The Director of Nursing/ Designee to complete quality review of any code blue event to make certain record reflects proper documentation. Audits of code blue events, change of condition, transfer forms, if applicable, MD notification, and resident representative notification. Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.	
F 921 SS=J	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional,	F 921		

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F 921	Continued From page 38 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Cross Reference F689 Based on observations, interviews and record reviews, the facility failed to provide a safe environment, free from flooring hazards for staff, the public, and 19 ambulatory residents in the facility's secure memory care unit. One (Resident #6) of the 19 ambulatory residents on , sustained a to the right (top of bone), required a transfer to a higher level of care, and surgical intervention due to a floor repair that was not completed by the facility. The injuries to Resident #6 caused a significant decline in her ability to ambulate and complete activities of daily living (ADLs) at her prior functional level. The facility's failure to maintain a safe walking environment caused serious injury and harm to Resident #6 and placed 18 additional ambulatory memory care residents, staff, and visitors at risk for serious injury, harm, and/or . This failure resulted in the determination of Immediate Jeopardy on . The findings of Immediate Jeopardy were determined to be removed on and the severity and scope was reduced to a "D." Findings included: A review of an electronic work order created on at 6:31 p.m. by Staff G, Licensed Practical Nurse (LPN) revealed "clean out cover missing," location 200 hallway, priority level	F 921	1. Immediate action(s) taken for the resident(s) found to have been affected include: Administrator and Director of Maintenance performed environmental rounds, identified areas of concern noted and reported in Electronic Maintenance System. Repairs on all items identified were completed prior to survey exit on . Resident # 6 no longer resides in the facility. 2. Identification of other residents having the potential to be affected: Quality review completed for monitoring of environmental hazards with a focus on uneven surfaces and hazards; Administrator/Designee rounded facility to survey for environmental hazards; Identified environmental concerns reported via Electronic Maintenance System, addressed by priority level, and completed 3. Actions taken/ systems put in place to reduce the risk of future occurrence include: Administrator/Director of Clinical Services/Maintenance Director re-educated on ensuring resident environment is free of hazards with emphasis on timely completion; Director of Clinical Services/Designee re-educated staff on Accidents and Supervision Policy; Director of Clinical Services/Designee	

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medium, and a note/comment to "repair drain on 200 hallway asap [as soon as possible]." The status of the order was updated by the Director of Maintenance (DOM) on at 2:49 p.m. as "Set to Completed." A Room Audit Form, for "Project Clean OUT 200 Hall" with a start date of revealed daily notes monitoring the clean out cover area from to documented by the DOM. The first entry on the log, dated , showed the (DOM) placed a metal sheet cover over the drain opening with tape. The entry on , the day the work order status was updated, showed a visual inspection was done in the morning and fresh tape was applied that evening. None of the entries between and showed any additional work outside of visual inspection and applications of fresh tape was completed. A review of the audit log revealed no documentation to show the area was visually inspected to ensure safety of residents, staff, and visitors on , , , , , , , , , , , , and . The log showed on "morning - Resident [#6] , fresh tape -plumber called -Received Quote & Sent." The log showed on "evening - Job completed." A review of an email dated confirmed the plumbing company had completed a repair of the area on the 200 hall on , 4 days after Resident #6 and 37 days after the original work order was created.

During a facility tour on at 10:30 a.m. an area of rough and uneven concrete approximately 3ft ( ) x 2 ft in the middle of the corridor of the 200-hall located inside the memory care unit. The uneven concrete area had a drain cap located near the middle that was raised. The concrete

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re-educated staff on Recognizing & Reporting Hazards; Director of Clinical Services/Designee re-educated staff on Redirecting Residents with from Environmental Hazards; Director of Clinical Services/Designee re-educated staff on securing hazardous areas until plant ops clears, ensuring no harm; Initiation and Assignment of direct care staff member as Hallway Safety Monitor for secure unit (200 Hall) for additional supervision and hazard identification.

4. How the corrective action(s) will be monitored to ensure the practice will not reoccur:
Administrator/Director of Maintenance/Designee will round to ensure facility is free of hazards twice weekly x 8 weeks; then weekly ongoing. Quality reviews will be completed once a week x8 weeks and then every 2 weeks x1 month. Quality reviews will be reviewed by the QAPI committee monthly x 3 months or until substantial compliance is met along with quarterly reviews.

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area was a known high-traffic area, outside of the secured memory care dining room, the nurses' station, and just outside of Resident #6's room.

A review of Resident #6's admission record revealed the resident was , originally admitted to the facility on , with a recent hospital stay from to . The record showed diagnoses to include a displaced of base of of right subsequent encounter for closed with routine healing, aftercare following , replacement surgery, difficulty in walking, presence of right , , and and other classified elsewhere unspecified severity with agitation.

A review of the Situation, Background, Appearance, and Review (SBAR) evaluation for Resident #6, dated , showed the resident tripped and in the hallway, complaining of lower and right , . The evaluation revealed new , in the right , lower and right with an intensity score of 9 of 10. The documentation revealed the resident was left in place due to , on movement, and the primary physician placed an order to send the resident to the Emergency Room (ER) for evaluation on at 8:40 a.m.

An interview on at 1:34 p.m. with Staff C, Certified Nursing Assistant (CNA) revealed she witnessed Resident #6's incident on . Staff C, CNA reported Resident #6 was in the hallway with her Family Member (FM). The resident was attempting to detach herself from tape on the floor in the unrepaired plumbing area that was covered with concrete. The staff member stated the tape was not holding anything down. Staff C saw Resident #6 lose her balance

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F 921	Continued From page 41 and . Review of a written statement by Staff C, CNA dated at 8:30 a.m. showed Staff C was coming down the hall with a breakfast tray and witnessed Resident #6 trip and over an area on the floor. The tape was coming up and Resident #6's got caught on it. A review of Resident #6's hospital History and Physical Report, dated at 12:59 p.m. revealed "This is a female with medical history of , dyslipidemia, [,], nursing home resident, presented to hospital for [sic] facility after a . Patient was found on the ground and complaining of right , , patient's baseline is , only be able to recognize her [FM], but nobody else, be able to eat by herself. When I saw the patient, her [FM] at bedside, provided all the history." The completed , imaging studies, on at 10:44 a.m. showed a right . The Computed , , Scan (CT) of the , without contrast, on at 10:04 a.m., revealed " , right with angulation and mild displacement." The results of the right and right , with showed "normal ." A review of a hospital consultation note dated at 6:04 p.m. showed the resident was complaining of right , , and the physical examination showed the right lower extremity was shortened and externally rotated. The assessment/plan showed resident "would benefit from , intervention of the right , in order to provide stability to the and promote satisfactory healing, to improve , , to facilitate early motion and mobilization and to	F 921		

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prevent complications associated with prolonged bedrest." The risks, benefits, complications, and alternatives treatments were explained to the patient and FM. This included "the possibilities of , , , reaction to , , compromise, or dying on the table, incomplete relief of symptoms, and , or stiffness."

A review of the , report on at 9:08 a.m., showed Resident #6 had undergone a right , , , . The post- , , results showed the , was "well-seated" with no evidence of hardware loosening or failure.

A review of the hospital , , , ( ) evaluation dated at 9:38 a.m., revealed the FM had reported a prior functioning of being able to mobilize with a walker. The assessment showed " , /Limitations: Ambulation , Bed mobility , , Range of motion , Safety awareness , Transfer , Transition
Barriers to Safe Discharge: Insight into , Needs Assist for Mobility, Needs Assist for Transfer, Safety awareness
Summary of Findings: . [patient] very , unable to follow commands, dep[endent] for all mobility.

A review of a facility note dated at 5:30 p.m., showed Resident #6 returned to the facility from the hospital following a right , , , . The record showed the resident was in , whenever touched. The resident had a surgical on right , and staff recommended rehab unit for the resident.

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During an interview on at 2:15 p.m., the Director of Nursing (DON) stated Resident #6 had been ambulating in the hallway with a family member and her kind of got stuck on tape. The DON reported the FM grabbed the resident had pulled her, then the resident lost her balance and . The DON stated the resident had a history of , and because of right , , the resident was left on floor. The DON stated she interviewed Staff B/CNA, Staff C/CNA, and Staff E, Licensed Practical Nurse (LPN). The DON stated Staff E, LPN was sitting at the desk and did not witness the , but heard the resident call out and saw her lying on the right side. The DON confirmed Resident #6 suffered a , was transferred out to the hospital, had surgery and came to the facility. The DON stated Resident #6 had suffered a previous on . She stated the resident had a big chair in her room at the time so the family "decluttered" the room and when the resident started ambulating, the facility ensured the environment was free of clutter and slip hazards to prevent additional .

On at 9:45 a.m., an interview was conducted with the DOM. He stated on 200-hall, the memory care unit, a resident had pulled the clean-out cap off, on . The DOM reported "roping" the area off and cutting a metal piece to fit on top of the missing cap. He stated this was done after Resident #6 had . The DOM stated the facility had plumbers come in on . The DOM stated from to , he had put several patches on the area, and went every day to make sure it was secure and safe. The DOM reported the plumbers removed the tile all the way around the

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clean out cap, leaving a cemented patch.

On at 10:46 a.m., the DOM observed the 200 hall and showed the area where Resident #6 had in the hallway. The area was near the nursing station in the 200-hall and just outside of Resident 6's room at that time of the incident. The DOM observed an additional area of missing floor tiles on the 200 hall and stated the facility had just received the diamond blades to smooth out the concrete. He stated the plumbers had to remove the tiles to fix a plumbing issue. During the time of this interview, the DOM confirmed the area where Resident #6 had was still uneven due to the concrete patch left by the plumbers on .

An interview was conducted on at 12:00 p.m. with Staff J, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member described the area of concrete as similar to other drains on unit, showing a circular drain with a square metal outer plate. Staff J, LPN/UM stated the residents on the unit like to pick at it and had pulled the square metal plate up. Staff J, LPN/UM stated maintenance had covered the area with a metal square that was approximately the same size as the missing plate and secured it to the floor with yellow and black striped industrial tape so it would be recognized as a caution area. Staff J, LPN/UM stated she doubted the residents in the memory care unit would have recognized the tape as a caution area. The staff member stated the concrete area was a high-traffic area as it was between the dining room, Resident #6's room, and the nursing station on the memory care unit. Staff J, LPN/UM stated they had a lot of residents up and down the hallways due to on the unit. Staff J, LPN/UM said she

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could only report it to maintenance, and then it was out of her . Staff J, LPN/UM stated the metal and tape was a hazard, and during the repair period, the area had become larger in size.

A follow-up interview on beginning at 3:05 p.m. with the DOM revealed the rough concrete patch observed during the survey beginning on was part of the repair. The DOM stated he had to research a replacement cap since the missing cover was so old. The DOM stated the plumber did not have a cap to fit the iron piping, so the plumber had to make the hole bigger and cut pipe to fix it. The DOM revealed this repair happened in the middle of . The DOM stated he had put a metal plate on the area trying to save the company money in . The DOM reported he was researching it to try to fix it himself before calling the plumbers in, but after Resident #6's , he was done searching for the replacement and decided to get plumbers in. The DOM stated he felt the location where Resident #6 was safe and felt the [brand name] tape was a good tape to use as a temporary fix. The DOM reported the diamond grinding wheel, needed to smooth out concrete, had been ordered and came in "last week." The DOM said he had looked at local merchants for the grinding wheel, but they did not have the size needed in stock. The DOM stated the diamond wheel was delivered on , the day before he went on vacation. Review of the online merchant's receipt for the 4.5-inch diamond concrete grinding wheel showed the order was placed on and shipped on . At the time of this interview, the area where Resident #6 was still not fully repaired leaving a rough and uneven flooring surface in this high traffic area.

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On at 2:04 p.m., the Regional DOM reported not being aware of the flooring issue. The Regional DOM stated depending on severity, if something could not be handled in-house the facility contacted vendors for repairs. The Regional DOM expected something to be implemented promptly, within one to two weeks for the safety of the residents.

On at 10:18 a.m., a second area in hall 200 towards the front of the facility, near the janitor supply closet #3 was observed with 12 missing tiles. The area was in the walking path of residents in the memory care unit. The area had a raised drain with a cap near the middle of it. An immediate interview was conducted with Staff B, Certified Nursing Assistant (CNA) who confirmed the area had been in disrepair for a "long time" and estimated it to be approximately 6 to 8 months.

A review of a work order dated at 2:24 p.m. showed Staff J, LPN/UM reported missing tile on the floor of the 200 hallway with a medium priority level. The work order was acknowledged by the DOM on at 3:30 p.m. with a status of "Set to-In-Progress." The work order was updated on at 2:17 p.m. by the DOM with a status of "Set to completed."

On at 10:38 a.m., the entrance ramp to the 400-hall was observed missing five full carpet squares (approximately 2 ft x 2 ft) and 5 half carpet squares leaving exposed concrete with a raised drain that was not level to the concrete, and the carpet that remained was not level with the concrete. A yellow traffic cone was placed in the corner from the hallway to the ramp. This

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area was the inside entrance for residents, staff and visitors to access the 400-hall and used frequently by residents with ambulation devices and wheelchairs.

During a facility tour of the 200 hall on at 2:21 p.m. with the Nursing Home Administrator (NHA), revealed tiles that were popping up on the edges where the facility had replaced flooring using old tiles. The NHA confirmed the area was a hazard for someone with a shuffling gait. The NHA stated the tiles needed to be put down again and better. The NHA stated her expectation was an immediate fix for any hazard affecting residents. The NHA observed the area where Resident #6 and stated she expected the area to be safe for the residents. The NHA stated it was unacceptable to wait to repair the floors.

Photographic evidence was obtained.

A review of the Maintenance Director's job description signed on by the DOM revealed:
Position Purpose: "Directs the day-to-day activities of the maintenance department in accordance with current federal, state, and local standards, guidelines and regulations governing the facility, and to ensure the facility is maintained in a safe and comfortable manner."
The major duties and responsibilities included:
"Plans, develops, organizes, implements, evaluates, and directs the Maintenance Department, its programs and activities.
Ensures the facility remains in compliance with all federal, state, and local regulations for life safety code compliance.
Reviews the department's policies, procedure manuals, job descriptions, etc., at least annually

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for revisions and makes recommendations to the Assistant Administrator/Administrator.
Prepares operating and staffing budgets for maintenance and monitors monthly.
Ensures maintenance staff are properly trained on safety policies and procedures as well as monitors compliance.
Ensures proper planning, direction, participation, and supervision of both preventative and unplanned maintenance and repair activities in the facility, which includes painting, plumbing, carpentry, HVAC, and electrical work.
Purchases within budgetary responsibilities [sic] the general maintenance tools, supplies and equipment, safety equipment, and trains others in their appropriate use.
Ensures that services performed by outside vendors are properly completed/supervised in accordance with contracts/work orders...
Ensures facility's compliance with multiple OSHA standards ...
Develops and implements preventative maintenance tasks, document instructions and procedures for the preventative maintenance of facility and utility components and office equipment, as well as, mechanical, air conditioning, heating, and electrical systems, etc.
Schedules department work hours (including vacation and holiday schedules), personnel, work assignments, etc., to expedite work...
Ensures the facility's compliance with the law and other regulatory terms such as safety and building codes ...
Runs, operates, and assesses technical aspects of facility machinery, equipment, and buildings."

A review of the Job Description for the Administrator signed on revealed:

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Position Purpose: "Leads, guides, and directs the operations of the health care facility in accordance with local, state, and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents."
The major duties and responsibilities included:
"Plans, develops, organizes, implements, evaluates and directs the overall operation of the facility as well as its programs and activities, in accordance with current state and federal laws and regulations.
Plans, develops, organizes, implements, evaluates, and directs the facility's programs and activities in accordance with guidelines issued by the governing body.
Identifies, in conjunction with the Director of Nursing and selected department heads, the facility's key performance indicators. Establishes an ongoing system to monitor these key indicators such as the Quality Assurance and Performance Improvement process throughout the facility ...
Leads and coordinates daily, weekly, bi-monthly or monthly management team meetings to discuss priorities and develop solutions with facility leaders such as census, collections, clinical health, survey readiness, customer service satisfaction, activity participation, etc ...
Evaluates work performance of department heads and maintains accountability across all departments in concert with Human Resources for expected performance outcomes in each respective department...
Knows and understands ...Code of Federal Regulations, Appendix PP State Operations Manual ...Life Safety Code regulations ...and all other regulatory entities that may apply ...
Performs rounds to observe residents and ensure

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overall needs are being met. Knows residents by name and sight. Practices management by walking around. Makes himself/herself available to employees at all levels by practicing an open-door policy.

A review of the policy titled, Safe and Homelike Environment, implemented , revealed: "In accordance with resident's rights, the facility will provide a safe, clean, comfortable, and home like environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk." Definitions included: "Environment" refers to any environment in the facility that is frequented by residents, including (but not limited to) the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, , , areas, and activity areas; "Orderly" is defined as an uncluttered physical environment that is neat and well-kept.
Policy explanation and compliance guidelines: Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment.
General Considerations: Report any unresolved environmental concerns to the Administrator.

A review of the facility's immediate actions to remove the Immediate Jeopardy included:
1. Immediate Action:
NHA and Plant Operations Director performed environmental rounds on , identified areas of concern noted and reported in the electronic maintenance records system. Work orders started in order of priority for hazards

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causing uneven surfaces, risk hazards, and items with potential to risk resident safety.
Summoned Corporate Plant Operations support team for assistance on
Initiated repairs of identified areas of concern on

Tiles in high traffic area of secure unit (200 Hall, outside) repaired on , part of repaired tiles began to shift, tiles replaced again on .
Tiles in high traffic area of secure unit (200 Hall, outside) repaired on
400 Hall ramp missing carpet tiles replaced on , carpet tile surface continues to be uneven, all carpet tiles were removed from ramp and replaced with one solid carpet piece.
On surveyors and NHA completed environmental rounds of the facility noting areas of continued concern.
List compiled of concerns from environmental tour, all items entered in the electronic maintenance records system.
300 Hall clean out with uneven surface repaired.
99.5% of all facility staff were educated by 9:00 a.m. on .
Initiated and assigned direct care staff member as "Hallway Safety Monitor" on secure unit (200 Hall) for additional supervision. Hallway Safety Monitor will be assigned 24 hours a day X 7 days to establish a pattern of ambulatory residents. When pattern is established, Hallway Safety Monitor will be staffed from 0700 to 2300 daily X 14 days. Then, as pattern is further established, Hallway Safety Monitor will be staffed 12 hours daily X 30 days. Hallway Safety Monitor staffing hours will be adjusted as indicated.
2. Identification of others at risk was accomplished by:
Quality review completed for monitoring of

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environmental hazards with a focus on uneven surfaces and hazards.
NHA/Designee rounded facility to survey for environmental hazards.
Identified environmental concerns reported via electronic maintenance records system, addressed by priority level, and repairs initiated and will be ongoing
3. Actions to Prevent Occurrence/Recurrence:
NHA, DCS (Director of Clinical Services), and Plant Operations/Maintenance Director re-educated on ensuring resident environment is free of hazards with emphasis on timely completion.
DCS/Designee re-educated staff on Accidents and Supervision Policy.
DCS/Designee re-educated staff on Recognizing & Reporting Hazards.
DCS/Designee re-educated staff on Redirecting Residents with from Environmental Hazards.
DCS/Designee re-educated staff on securing hazardous areas until plant ops clears, ensuring no harm.
Initiation and Assignment of direct care staff member as "Hallway Safety Monitor" for secure unit (200 Hall) for additional supervision and hazard identification.
A Performance Improvement Plan (PIP) has been initiated to report on the above monitoring and auditing procedures. All findings from the PIP will be presented at the monthly Quality Assessment & Assurance (QAA) meeting. Monitoring/auditing and reporting will continue for a minimum of three months or until substantial compliance is determined.
4. NHA/Plant Ops/Designee will round to ensure facility is free of hazards daily X 7 days, then daily X 5 days, then twice weekly x 8 weeks; then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105354	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND NURSING & REHABILITATION	1919 LAKELAND HILLS BLVD LAKELAND, FL 33805

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weekly and PRN (as needed) as indicated. These audits will be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the assigned auditors for three months.

Verification of the facility's removal plan was conducted by the survey team on .

On observations were made to ensure the facility repaired the concrete area in the 200-hall to include level tiles and repaired the area at the end of the 200-hall to ensure the tiled area was level. The facility removed the carpet on the 400-ramp and replaced it with two pieces of rolled carpet. The facility educated 99% of their staff on notifying supervisors of accident hazards and to notify other management if the hazard was not repaired.

Interviews were conducted with 77 staff members, which included the NHA, the DOM, 13 licensed nurses, 17 CNAs, and 45 other staff members across all shifts. The staff members were able to state that they had been trained and were knowledgeable about the new procedures. Interview with the NHA on revealed a couple of the staff were not reachable, but a system was put into place for education prior to their next working day.

Based on verification of the facility's Immediate Jeopardy removal plan the immediate jeopardy was determined to be removed on and the non-compliance was reduced to a scope and severity of "D."