STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105439	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKESIDE PAVILION	**2900 12TH STREET N NAPLES, FL 34103**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff and resident interview the facility failed to promote the rights to retain and use their personal possessions for 5 (Resident #2, #3, #5, #1, and #6) of 5 residents interviewed by not ensuring the timely processing of personal laundry. The findings included: On 9/1/20 at 9:15 a.m., during an interview Resident #2 said she did not have her clothes. She said she was wearing someone else's clothes and did not have her own clothes. On 9/1/20 at 9:20 a.m., Resident #3 said some days she hardly had any clothes. She said, there are many people sick with the disease and they do not wash or bring the clothes timely. On 9/1/20 at 9:35 a.m., during a tour of the facility Licensed Practical Nurse Staff B said there was an ongoing situation in the building with the laundry. She said, sometimes there is no one working in the laundry. The dirty clothes are piling up and they take a very long time to get it back to the residents. On 9/1/20 at 9:45 a.m., during an interview with Resident #5 she pointed to a pair of black shorts she was wearing and said, that's my second pair of shorts in 3 weeks. She said the laundry was backed up and she was left with 2 pairs of clean underwear. On 9/1/20 at 9:50 a.m., during a tour of the laundry room the following observations were made: The clean side of the laundry had 3 large overflowing bins of laundry covered with a blanket. A full rack of clothes was observed partially covered with a sheet. * Photographic evidence obtained* The soiled side of the laundry had 2 large overflowing bins of dirty laundry covered with a blanket. The Administrator was present during the observation. * Photographic evidence obtained* On 9/1/20 at 9:50 a.m., during an interview the laundry room supervisor said she had been employed at the facility for approximately 1 week. She said, I walked into a pretty big mess. I am trying to catch up. She said there were lots and lots of personal clothes that needed to get out to the residents, but she was not caught up. The laundry room supervisor said currently there were only 2 people working in the laundry. She said, It is not enough. The laundry room supervisor said she was the only one working that morning and did not have enough help. On 9/1/20 at 10:45 a.m., during an interview with the Administrator he said he was aware of the laundry concern and had been working with the contracted company since June 2020 and demanded an action plan to solve the problem. He said with the pandemic it had been a challenge bringing staff in the building. He said last week they brought additional help to wash the clothes and redistribute them to the residents. Unfortunately, some of the clothes are not labeled. They had been working on getting the clothes back to the customers. Review of the document titled Action plan May-[DATE] revealed the action plan for the laundry room was Organize and deep clean laundry room. Hired new full-time Laundry Aide awaiting background and negative Covid 19 test results. We also have part time laundry aides at this time. The target date was 8/18/20 and the finish date was ongoing. On 9/1/20 at 11:40 a.m., during an interview Resident #1 said she had not had any clean clothes since a week ago Monday. The resident said she had been asking the laundry for her clothes for days now. The resident said she had been wearing the same clothes over and over again. Observation of the resident's closet revealed 3 shirts and 3 pairs of pants. Resident #1 said she hung them back in the closet after wearing them because she was afraid of running out of clothes. Resident #1 had her call light on during the interview. The scheduler knocked on the door and entered the room. Resident #1 complained to her she's been asking about her clothes for days now and did not have anything clean to wear. On 9/1/20 at 11:55 a.m., interview with Resident #6 revealed he's been missing 5 pullovers for approximately 2 months. He said he complained about it, but they are still missing. On 9/1/20 at 12:25 p.m., during an interview the Regional Manager for the contracted laundry company acknowledged the delay in washing and returning personal clothing items to the residents. She said she will provide additional staff to the building until it was all completed. Review of the grievance log from 3/1/20 through 8/26/20 revealed 45 grievances related to missing items. Review of the resident council minutes for 6/1/20 revealed documentation Residents said that they are . tired of laundry not returning clothes, tired of not having clothes. On 9/1/20 at 2:55 p.m., during an interview the Activity Director said she had not typed the minutes for the last resident council meeting held on 8/28/20 but the residents complained of basically the same thing. They are tired of not having their personal clothes not returned to them.
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to provide necessary housekeeping services to ensure a safe, clean, comfortable and sanitary environment for residents on 2 (North and South Units) of 2 units of the facility. The findings included: On 9/1/20 at 9:10 a.m., during a tour of the facility the following observations were made: room [ROOM NUMBER]'s bathroom had a dirty lamp stored on the floor next to the toilet that was used by 4 different residents. An assist toilet rail to the left side of the toilet had a broken hand rest with sharp edges. * Photographic evidence obtained* The South Shower room used for multiple residents had a white shower chair with a large amount of dried up brown and orange substance underneath the seat and on the shower chair legs. The back leg of the chair had a broken wheel. * Photographic evidence obtained* Observation of the North Shower room revealed a white wobbly shower chair with a large amount of dried up brown and orange substance underneath the seat and the shower chair legs. The front bar of the shower chair legs was missing. *Photographic evidence obtained* A soiled incontinent brief was observed in the uncovered garbage can next to the sink. Used towels were observed in the sink. *Photographic evidence obtained* The wall across from the sink had dried up brown substance. *Photographic evidence obtained* The corner between 2 walls of the shower had a large amount of dried up brown and orange substance. *Photographic evidence obtained* On 9/1/20 at 9:22 a.m., room [ROOM NUMBER] was observed with a rusty raised toilet seat that is used for 4 residents. On 9/1/20 at 9:25 a.m., during an interview with housekeeper Staff A she said she is assigned to clean 21 to 22 rooms daily. She said she did not have the time to do it perfectly. She said it's a lot of work and tries her best. On 9/1/20 at 9:40 a.m., room [ROOM NUMBER] had a soiled, stained privacy curtain. *Photographic evidence obtained* On 9/1/20 at 10:15 a.m., observation of the North Unit linen closet revealed crumpled paper towels on the floor. *Photographic evidence obtained* The inner side of the linen closet door had streaks of dried up black substance from the top to the bottom of the door. The floor behind the door had a large amount of black substance. *Photographic evidence obtained* Linen was observed on the floor underneath the shelves. Part of a pink blanket stored on the shelf was resting on the floor. *Photographic evidence obtained* On 9/1/20 at 10:20 a.m., observation of the South Unit linen closet revealed linen stored on the floor underneath the shelves. *Photographic evidence obtained* The corner of the floor behind the door had a large accumulation of black substance. *Photographic evidence obtained* The Administrator was present during the observation and verified the floor was not clean and the linen was stored on the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) floor. On 9/1/20 at 1:55 p.m., the privacy curtain in Resident #1's room had a large brown stain. On 9/1/20 at 1:55 p.m., Resident #1 said the curtain had been stained since she moved into the room over a month ago. On 9/1/20 at 10:45 a.m., during an interview the Administrator said he's been working with the contracted housekeeping company for approximately 2 months to have the issues resolved. He said he did not look behind the clean linen closet doors while going through the process. The Administrator said he had requested a new chair for the South Unit shower room this morning and asked the Maintenance Director to remove the soiled broken chair from the shower room. He said he did not understand why the chair was still there. The Administrator provided documentation of an action plan for housekeeping for May through September 2020. The action plan included the resident's rooms with a target date of 6/30/20, and the walls, baseboards and doors with a target date of 5/20/20. The action plan did not include the shower rooms and the linen closets. On 9/1/20 at 12:25 p.m., during an interview with the Regional Manager for the housekeeping contracted company she said she will provide additional staff to the facility until the facility cleaning is completed.