

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 105439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2020
NAME OF PROVIDER OF SUPPLIER LAKESIDE PAVILION		STREET ADDRESS, CITY, STATE, ZIP 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 0584 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview the facility failed to maintain resident transfer equipment in a sanitary manner for 2 of 4 lifts used within the facility. Transfer lifts are used to assist residents from moving from one position to another position. The findings included: 1. On 3/11/20 at 9:23 a.m., observation in the North Unit revealed a patient transfer lift to have heavy soiling on the footrest with visible soiling of both left and right handgrips. On 3/11/20 at 9:23 a.m., the Director of Nursing (DON) confirmed the transfer lift was soiled and required immediate cleaning. 2. On 3/11/20 at 10:40 a.m., observation in the South Unit revealed a patient transfer lift to have heavy soiling on the footrest with visible soiling of both left and right handgrips. On 3/11/20 at 10:40 a.m. the DON confirmed the transfer lift was soiled and required immediate cleaning. *Photographic evidence obtained*		
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.