| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105302 | A. Building<br>B. Wing | 07/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oak Haven Rehab and Nursing Center | 919 Old Winter Haven Rd<br>Auburndale, FL 33823 |

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 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the medical record was complete related to Activities of Daily Living (ADLs) for 3 of 3 sampled residents (#1, #2, #3)Findings included:<br><br>1. Resident #2 was admitted on [DATE]. Review of the admission Record showed diagnoses included but not limited to Parkinson’s, dementia, anemia, and hypotension. Review of the Minimum Data Set (MDS) dated [DATE] showed Section GG, Functional Abilities dependent for toileting hygiene, showering and bathing, upper and lower body dressing.<br><br>Review of the care plans showed the resident had an ADL self-care deficit related to chronic medical conditions. ADL needs and participation vary as of 07/18/2022. Interventions included but not limited to encourage and assist with all ADL tasks as indicated, as tolerated by resident, including locomotion/ambulation, bathing, bed mobility, transfers, toileting tasks, meals, personal/oral hygiene, etc. as of 07/18/2022.<br><br>Review of the Activities of Daily Living for June 2025 showed<br><br>bed mobility, behavior symptoms, bladder continence, bowel management, dressing, float heels while in bed, evening snack, locomotion off unit, locomotion on unit, oral care, personal hygiene, skin observation, toilet use, transferring, turning and positioning, walking in corridor, walk in room, amount eaten with fluids, eating, incontinence care every 2 hours and as needed was not documented as performed on the following dates: 07/03/25, 07/05/25, 07/07/25, 07/08/25, 07/10/25, 07/11/25, 07/16/25, 07/1925, 07/21/25, 07/2325, 07/24/25.<br><br>During an interview on 07/28/2025 at 12:43 p.m. the Director of Nursing (DON) stated the ADLs for Resident #2 had not been documented as performed on the above dates. She stated she expected to see documentation of tasks performed.<br><br>2. Resident #3 was admitted on [DATE] and readmitted on [DATE]. Review of the admission Record showed diagnoses included but not limited to diabetes, Alzheimer’s disease, hypertension and dementia. Review of the quarterly MDS dated [DATE] showed a BIMs score of “0” or resident is rarely, never understood. Section GG, Functional Abilities showed she was dependent for toileting hygiene, shower and bathing, upper and lower dressing, and personal hygiene.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the care plan showed Resident #2 has an ADL self-care deficit related to chronic medical conditions as of 04/15/2025. Interventions included but not limited to the resident may need dependent assistance of one or two for ADL care. This may fluctuate with weakness, fatigue, and weight bearing status as of 04/15/2025. The resident is not able to participate in this task as at all (toileting) and will need staff to move, cleanse, and dress them. This may require the dependent assistance of 2 people to be done thoroughly and safely as of 11/21/2024.<br><br>Review of the Activities of Daily Living from 06/29/225 to 07/28/2025 showed<br><br>Urinary Incontinence the following dates only has 1 or 2 incontinence activities performance documentation: 06/29/2025, 06/30/2025, 07/03/2025, 07/04/2025, 07/06/2025, 07/08/2025, 07/10/2025, 07/13/2025, 07/14/2025, 07/18/2025, 07/22/2025, 07/27/2025 and no documentation on 07/26/2025.<br><br>Bowel Incontinence the following dates only has 1 or 2 incontinence activities performance documentation<br><br>06/29/2025, 06/30/2025, 07/03/2025, 07/04/2025, 07/06/2025, 07/08/2025, 07/10/2025, 07/13/2025, 07/14/2025, 07/18/2025, 07/22/2025, 07/27/2025 and no documentation on 07/26/2025.<br><br>Toilet Use Self Performance the following dates only has 1 or 2 incontinence activities performance documentation: 06/29/2025, 06/30/2025, 07/03/2025, 07/04/2025, 07/06/2025, 07/08/2025, 07/10/2025, 07/13/2025, 07/14/2025, 07/18/2025, 07/22/2025, 07/27/2025 and no documentation on 07/26/2025.<br><br>During an interview on 07/28/2025 at 1:06 p.m. the DON verified documentation was missing for Resident #3 regarding incontinence care. The DON stated she expected the staff to document incontinence care.<br><br>Review of the facility’s policy, “Documentation,” revised 01/2024 showed services provided to the resident shall be documented on the resident’s medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident’s condition and response to care. Procedure: 2. The following information is to be documented in the resident medical record: C treatments or services performed; 8. Documentation of procedures and treatments will include care specific details, including: a) the date and time the procedure / treatment was provided; B) the name and title of the individual (s) who provided the care; D) whether the resident refused the procedure / treatment; f) the signature and title of the individual documenting.<br><br>Review of the facility’s policy, “ADL Care and Services,” revised 01/2024 showed residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Guideline: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Procedure: 1. Residents will be will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) are met. 4. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:<br><br>a. hygiene (bathing, dressing, grooming, nail care and oral care);<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. Mobility (transfer and ambulation, including walking);<br><br>c. Elimination (toileting).<br><br>Review of the Record for Resident # 1 indicated diagnoses which included Type II Diabetes mellitus with foot ulcer, Type 2 Diabetes mellitus with Hyperglycemia, Encounter for removal of internal fixation device, Hyperthyroidism, PVD, Obesity, Hyperlipidemia, Gastro-esophageal Reflux Disease and Gastritis.<br><br>Review of a discharge Minimum Data Set Assessment) dated 5/20/25 indicated Section GG Functional Abilities:<br><br>Substantial /maximal assistance for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene<br><br>Review of the care plan for ADL Care, initiated 3/25/25, revealed:<br><br>BED MOBILITY: the resident needs EXTENSIVE help to move and reposition the bed. Will need one- or two-person assistance to change position or scoot up in the bed. This may involve some lifting of the legs or boosts.<br><br>TOILETING: the resident will need the EXTENSIVE help of one or two staff to stand and transfer on and off the commode or bed pan. The resident will probably need you to wipe, redress, and wash their hands, but allow the resident to do any part of the activity they can to promote independence. Be prepared with 2 people to assist for resident safety during the transfer<br><br>Transfer: the resident IS LIMITED TO EXTENSIVE and may need assistance x1 or x2 for transfers in and out of chair or bed<br><br>BATHING: The resident NEEDS ASSIST LIMITED TO EXTENSIVE of 1-2 based on fatigue, weightbearing, weakness.<br><br>Review of the Activities of Daily Living documentation from May 1 through May 20,2025 revealed bed mobility, behavior symptoms, bladder continence, bowel management, dressing, locomotion off unit, locomotion on unit, oral care, personal hygiene, , toilet use, transferring, turning and positioning incontinence care were not documented for the day shift and evening shifts on May 5,7,8,9,11, 12, 14,15, 19 2025.<br><br>During an interview with the DON, on 7/28/25 at 3: 37 pm, the DON confirmed the documentation of ADL care for the above dates was not documented. |