STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105302	A. Building B. Wing	04/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Haven Rehab and Nursing Center	919 Old Winter Haven Rd 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to file a grievance for one resident (#1) out of 3 residents reviewed for grievances.Findings included: Review of Resident #1's care plan note, dated 11/12/25 at 3:51 p.m., revealed a meeting was held by the Interdisciplinary Team (IDT) with Resident #1 and (via telephone) the resident's responsible party. The note showed concerns were addressed with the unit manager. Review of the November 2025 grievance log did not reveal any grievance had been filed by the resident, resident representative, or by the facility on behalf of the responsible party regarding concerns voiced during the IDT meeting and/or during the month of November. Review of Resident #1's admission Record revealed the resident was admitted on [DATE] and discharged on 11/14/25. An interview was conducted on 04/12/26 at 12:25 p.m. with the Social Service Director (SSD). The SSD acknowledged being the one in the facility handling grievances. The SSD reported when a family complains, the facility writes a grievance. The SSD stated if concerns are voiced during a care plan meeting, the concern is written as a grievance. The SSD read Resident #1's care plan meeting note, stated the SS assistant goes to the meeting, and the SSD did not know what Resident #1's concerns were. A continued interview was conducted on 4/12/26 at 12:45 p.m. with the SSD and a grievance filed on 11/9/25 in response to Resident #1's representatives feedback left on the facility's kiosk on 11/8/25. The SSD explained the representative had taken a survey upon exiting the facility, answering the feedback with a frowning face. The visit rating was 1 of 5 with key factors of nursing care, housekeeping/cleanliness, and customer service. The SSD provided a grievance written on 11/9/25. The SSD stated if family voiced concerns a grievance should have been written up. Review of a grievance (provided by the SSD), dated 11/9/25, based on information left by Resident #1's representative on the facility kiosk. The details of the complaint/grievance did not reveal any information, the SSD had investigated, and the investigation was a room change would be provided when available. The resident was notified of resolution on 11/10/25. The grievance did not reveal the resident representative had been contacted or any specific concerns had been voiced by the representative. The resolution showed the resident had and not the representative been notified of resolution. An interview was conducted on 4/12/26 at 1:46 p.m. with Staff A, Licensed Practical Nurse/Unit Manager. The staff member reported Resident #1 called the representative a lot and the unit manager would follow up with the representative, who voiced no concerns or issues. The staff member stated the representative was concerned about the resident's food allergies. Staff A stated they had spoken with the representative during the care plan meeting but didn't know of any concerns and just updated on the resident's medications (during the meeting). The staff member couldn't remember if the representative had any concerns and seemed to be satisfied. Review of policy - Grievances Resident Rights, revised 6/2023 revealed Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g. the State Ombudsman). The administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/ or representative.1. Any resident, family member, or appointed resident representative may file a grievance or complaint concerning care, (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment, behavior of other residents, staff members, theft of property, or any other concerns regarding his or her stay at the facility. Grievances also may be voiced or filed regarding care that has not been furnished.3. All grievances, complaints were recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to verbally and/or in writing upon request including a rationale for the response.8. A primacy of a grievance and/ or complaint, the grievance officer will review and investigate the allegations and submit a report of such findings to the administrator within five (5) working days of receiving the grievance and/ or complaint.10. The grievance officer, administrator, and staff will take immediate action to prevent further potential violations of residents rights while the alleged violation is being investigated.11. The administrator will review the findings with grievance officer to determine what corrective actions, if any, need to be taken.12. The resident, or person filing the grievance and/ or complaint on behalf of the resident, will be informed (verbally and/or in writing as per request) of the findings of the investigation and the actions that will be taken to correct any identified problems.14. The results of all grievances files investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility to failed to insert an indwelling catheter per physician orders for one (#6) of one resident sampled for urinary catheters and appropriately obtain vital signs for one (#1) of three residents sampled for monitoring of health conditions.Findings included: 1.On 4/12/26 at 9:35 a.m. an observation was made of Resident #6 lying in bed. The resident seemed minimally confused but answered questions appropriately. The resident reported the urinary catheter had come out at 3:00 a.m. this morning and was told staff were waiting for an aide to show up. The observation did not reveal a urinary drainage bag hanging near the resident. On 4/12/26 at 2:00 p.m. an observation was conducted with Staff A, Licensed Practical Nurse/Unit Manager (LPN/UM) of Resident #6. The resident was sitting in wheelchair next to bed, urinary catheter tubing was seen coming from dress hem to drainage bag hanging from chair. Resident #6 stated the catheter was not in the bladder but in the uterus. The staff member confirmed there was no urine in the drainage bag and an unknown certified nursing assistant (CNA) who was assisting the resident's roommate reported not draining the urine bag today. An interview was conducted on 4/12/26 at 2:05 p.m. with Staff A, LPN/UM and Staff B, LPN. The staff member reported getting in report (from off going nurse) this morning around 7:00 a.m. that Resident #6s urinary catheter had come out at 2:00 a.m. and the nurse had talked to the primary care physician about putting a 16 french (fr) [size] catheter in instead of the ordered 18 fr. Staff B reported putting a 16 fr in about a hour ago, and had informed the resident the staff member would be back to check on the resident. Staff A stated it was not appropriate to delay the insertion of catheter by approximately 9 hours. The staff members reviewed Resident #6's progress notes which did not include any notes from the previous nurse with a description as to why, how, or when the catheter had come out or the physician had been notified. Staff A stated the delay would only be appropriate if the facility was doing a toilet trail with the resident. Review of Resident #6's active physician orders revealed an order, dated 3/10/26 for an indwelling urinary catheter, 18 fr with 10 milliliter (mL) balloon for the diagnosis of neurogenic bladder. The orders showed the resident was currently receiving the antibiotic Levaquin 750 milligram (mg) daily for a urinary tract infection for 10 days, beginning 4/6/26. Review of Resident #6's progress notes showed Staff B had documented a late entry on 4/12/26 at 2:41 p.m. (35 minutes after interview). The note revealed the resident had not voided since the foley had dislodged (approximately 12 hours prior) and a foley was reinserted with the return of 300 mL's of clear yellow urine. Review of Resident #6's care plan showed the resident had a risk for injury/infection related to (r/t) presence of catheter secondary to a diagnosis (dx) of neurogenic bladder. The interventions included: catheter size and balloon as per MD orders, check catheter tubing for patency as indicated/needed, monitor and document intake and output per MD orders, monitor for signs/symptoms (s/sx) (of) bacteriuria which included no output, and observe/monitor for a change in urinary output, and notify MD as indicated. Review of the policy - Catheter Care, Quality of Care, revised on 01/2024 revealed The facility will maintain infection control guidelines related to catheter use and catheter care to minimize catheter associated infections. The guidelines showed the clinical nursing staff will receive education and training related to providing catheter care to minimize catheter associated infections.5. Changing indwelling catheters or drainage bags routinely and at fixed intervals that's not recommended. Rather, it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system was compromised at the discretion of the medical provider.7. Observed the resident routinely for complications related to catheter use. Report new complications to the provider per the change in condition policy. 2.Review of Resident #1's admission Record showed the resident was admitted on [DATE] and discharged on 11/14/25. The record included diagnoses not limited to unspecified chronic obstructive pulmonary disease, type 2 diabetes mellitus without complications, and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypertensive heart disease without heart failure. Review of Resident #1's November 2025 Medications Administration Record (MAR) showed an order for nursing staff to obtain vital signs every shift for 5 days, 11/8 - 11/12/25. The MAR revealed the following:11/8/25 evening and night shift: blood pressure (bp) 119/87, temperature (temp) 98.2, pulse 71, respirations (resp) 16, and oxygen saturation (O2) 98 (%).11/9/25 day and evening shift: bp 127/77, temp 97.8, pulse 68, resp 18, and O2 97%.11/9/25 night shift and 11/10/25 day shift: bp 139/71, temp 97.9, pulse 70, resp 18, O2 97%.11/11/25 day and evening shift: bp 100/62, temp 97.9, pulse 62, resp 17, and O2 97%11/11/25 night shift revealed identical bp as day and evening shift, 100/62 and NA (not applicable) for temp, pulse, resp, and O2.11/12/25 evening and night shift: bp 117/61, temp 97.6, pulse 73, resp 19, and 97% O2.The MAR showed the resident's vital signs did not change over consecutive shifts on same and different days. During an interview on 4/12/26 at 5:59 p.m., the Director of Nursing (DON) reviewed Resident #1's vital signs documented as the same on consecutive shifts and stated they were quite a coincidence. The DON would not comment on the likeliness of the resident having the same vital signs over multiple shifts. Review of policy - Documentation, revised 01/2026, revealed, Services provided to the residents shall be documented in the residence medical record. The medical records should facilitate communication between the interdisciplinary team regarding the residence condition and response to care. 2. The following information is to be documented in the resident medical record: c) treatments are services performed. d) Changes in the residents' condition.4. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.11. Late entries in the medical records shall be dated at the time of entry in noted as a late entry.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure skilled documentation for two (#1 and #7) of three residents sampled was completed daily, failed to ensure a change in condition and transfer evaluation was conducted for one (#1) of one sampled resident prior to transferring to an acute care facility, and failed to ensure one (#6) of one resident medical record contained documentation related to the dislodgement of an indwelling urinary catheter. Findings included: 1.An observation and interview were conducted on 4/12/26 at 9:20 a.m. with Resident #7 and spouse. The spouse reported wanting the resident to lay down after therapy but has not informed anyone of the wishes, will do so on Monday (next day). The resident was observed lying in bed with breakfast tray on the over-bed table. Review of Resident #7's admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to paroxysmal atrial fibrillation, hypertensive heart disease without heart failure, generalized muscle weakness, adult failure to thrive, and Encounter for surgical aftercare following surgery on the circulatory system. Review of Resident #7's active physician orders revealed the resident was receiving occupational therapy five times a week for 30 days starting on 3/28/26 and physical therapy five times a week for 30 days starting on 3/30/26. The orders did not include an order for a skilled daily note to be completed daily. Review of Resident #7's Assessments showed no skilled documentation on 3/30, 3/31, 4/4, 4/7, 4/10, and 4/11/26. An interview was conducted on 4/12/26 at 1:40 p.m. with Staff A, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member stated daily skilled notes are done for residents receiving therapy. She reviewed Resident #7's assessments which showed the resident was not receiving daily skilled assessments and stated they were working on trying to get nurses to remember to do the daily assessment and a progress note did not take place of the assessment. 2.Review of Resident #1's admission Record showed the resident was admitted on [DATE] and discharged on 11/14/25. The record included diagnoses not limited to unspecified chronic obstructive pulmonary disease, morbid (severe) obesity due to excess calories, generalized muscle weakness, and other abnormalities of gait and mobility. Review of Resident #1's November 2025 Medication Administration Record (MAR) showed staff had confirmed the documentation of a skill assessment daily on 11/8 - 11/10/25 during the day shift and 11/11 to 11/13/25 during the evening shift. Review of Resident #1's assessments showed on 11/8/25 an admission/readmission assessment was completed. The available assessments showed no skilled assessments from 11/9 to 11/13/25, despite staff documentation on the MAR showing the daily assessments had been completed. Review of Resident #1's progress notes on 11/11/25 at 8:10 a.m. showed Emergency Medical Services (EMS) were called per the resident's representative request. The note showed the resident had complained of itching as a result of an allergic reaction and redness was noted to bilateral upper extremities. The resident did receive an epinephrine injection prior to transferring to the acute care facility. The progress note did not show the resident's primary care physician had been notified. Review of Resident #1's progress notes showed on 11/11/25 at 1:38 p.m. the resident arrived back at facility via stretcher. Review of Resident #1's assessments showed no change in condition and/or transfer assessment had been completed at the time of the resident's allergic reaction episode or transfer to the acute care facility. Review of the policy - Change in Resident Condition or Status, Resident Rights, revised 6/2023, showed Facility shall notify the resident, his or her attending physician, and representative of changes in the residence medical/mental condition and/ or status (e.g. Changes in level of care, billing/ payments, residents rights, etcetera (etc.)). The guideline was To ensure the facility provides timely notification in accordance with state and federal regulations as it pertains to residents' rights.1. The nurse will notify their residents attending physician or physician on call when there has been a (an): g. need to transfer the resident to a hospital/ treatment center; i. specific (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instruction to notify the physician of changes in the residence condition.5. The nurse will record in the residence medical record information relative to changes in the resident's medical/ mental condition or status. 3.An observation and interview were conducted on 4/12/26 at 9:35 a.m. with Resident #6. The resident was observed lying in bed. The resident stated the catheter (urinary) had come out at 3 a.m. this morning and was told they were waiting for a Certified Nursing Assistant (CNA) to show up. The observation did not reveal the resident had a urinary catheter. Review of Resident #6's progress notes did not reveal a note describing the dislodgement of a urinary catheter on 4/11 and/or 4/12/26. Review of Resident #6's active physician orders included the following:Indwelling urinary catheter care every shift and as neededIndwelling urinary catheter: monitor every shift, notify the physician or changes in urinary appearance (color, consistency, odor, etc.) and/or no urinary output every shift.Indwelling urinary catheter size 18 french (fr) 10 milliliter (mL) for diagnosis of neurogenic bladder. An interview was conducted on 4/12/26 at 2:00 p.m. with Staff A. The observation with Staff A revealed urinary tubing under Resident #6's dress hem to the drainage bag. The staff member stated there was no urine in the drainage bag hanging from the wheelchair. The unknown CNA assisting Resident #6's roommate stated the drainage bag had not emptied today. An interview was conducted on 4/12/25 at 2:05 p.m. with Staff A and Staff B, LPN. Staff B stated she had gotten in report this morning at approximately 7:00 a.m. that Resident #6's foley (indwelling catheter) had come out at 2:00 a.m. and the night shift nurse had spoken with the primary care provider about putting in a 16 fr (size) instead of an 18 fr catheter. Staff B reported putting in a 16 fr catheter about an hour ago and had informed the resident she would be to check on the resident. Staff A stated it was not appropriate to delay the insertion by approximately 9 hours. Staff A and Staff B reviewed Resident #6s progress notes and confirmed the notes did not include information related to the dislodgement of foley and/or if the physician had been notified. Staff A stated the delay in inserting the catheter would only be appropriate if doing a toileting trial. An interview was conducted on 4/12/26 at 3:18 p.m. with the Director of Nursing (DON). The DON stated the skilled daily evaluations were for patients receiving therapy. She stated the expectation was for anyone getting therapy should have a daily skilled note. The DON stated the nurses are to get a physician order, complete a transfer form, and a change in condition assessment when a resident was transferred or a change in condition. A review of Resident #1's progress notes did not show the physician was notified of the resident being transferred or of the change in condition. The DON stated on 4/12/26 at 5:10 p.m. the facility had realized they had issues completing daily skilled notes. The DON reported the night shift nurse, Staff C, Licensed Practical Nurse (LPN) was a new nurse and had received one on one training with the electronic medical record. Review of the policy - Documentation, revised 1/2026, revealed Services provided to the residents shall be documented in the resident's medical record. The medical records should facilitate communication between the interdisciplinary team regarding the residence condition and response to care.2. The following information is to be documented in the resident medical record: a) objective observations. c) Treatments or services performed. d) Changes in the residents' condition. e) Care provided.3. Documentation in the medical record is required as updates/ changes in the residents plan of care is made.4. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.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;c) the assessment data and/ or any unusual findings obtained during the procedure/ treatment; e) notification of family, physician or other staff, if indicated.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to maintain an effective, comprehensive Quality Assurance and Performance Improvement program (QAPI) related to the development and implementation of corrective actions or performance improvement activities as evidence by the continued absence of daily skilled assessments for residents receiving skilled services.Findings included:Review of Resident #7's admission Record showed the resident was admitted on [DATE]. The record included diagnoses not limited to paroxysmal atrial fibrillation, hypertensive heart disease without heart failure, generalized muscle weakness, adult failure to thrive, and Encounter for surgical aftercare following surgery on the circulatory system.Review of Resident #7's active physician orders revealed the resident was receiving occupational therapy five times a week for 30 days starting on 3/28/26 and physical therapy five times a week for 30 days starting on 3/30/26. The orders did not include an order for a skilled daily note to be completed daily.Review of Resident #7's Assessments showed no skilled documentation on 3/30, 3/31, 4/4, 4/7, 4/10, and 4/11/26.An interview was conducted on 4/12/26 at 1:40 p.m. with Staff A, Licensed Practical Nurse/Unit Manager (LPN/UM). The staff member stated daily skilled notes are done for residents receiving therapy. She reviewed Resident #7's assessments which showed the resident was not receiving daily skilled assessments and stated they were working on trying to get nurses to remember to do the daily assessment and a progress note did not take place of the assessment.An interview was conducted on 4/12/26 at 3:18 p.m. with the Director of Nursing (DON). The DON reported the facility had identified an issue with skilled documentation and a Performance Improvement Plan (PIP) was started a couple of weeks ago. The expectation was for anyone getting therapy should have a daily skilled assessment. A continued interview was conducted on 4/12/26 at 5:10 p.m. with the DON. The DON reported and provided a copy of the PIP which started on 4/3/26. She stated the facility had educated all nurses on completing daily skilled notes and the goal was for all skilled residents would get them, if a note isn't done the facility calls the nurse back in. The Unit Managers are conducting audits of the skilled documentation. The administrator provided a detailed census report which listed 31 current residents receiving skilled services.Review of the audits completed showed audits were conducted on 4/5, 4/7, 4/9, and 4/11/26. The audits showed a total of 12 of the 31 residents had been audited for the daily skilled charting. The audit on 4/5 showed a total of 4 residents, of which 3 of those residents were also included among the five residents audited on 4/7. One of the residents had been audited on 4/5, 4/7, and 4/9. The audits did not show the clinical documentation of Resident #7 had been audited.During the interview on 4/12/16 at 5:10 p.m. the DON reviewed the audits conducted and confirmed the same residents were being audited. Review of the policy Quality Assurance and Performance Improvement (QAPI) program, undated, revealed This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI program are two:1. Provide a means to measure current and potential indicators of outcomes of care in the quality of life.2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators.3. Reinforce and build upon effective systems and processes related to the delivery of quality care and services.4. Established systems through which to monitor and evaluate corrective actions.