

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Lake Haven Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1351 San Christopher Dr Dunedin, FL 34698	

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)
<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on record review and interviews, the facility failed to protect residents' rights to be free from verbal and physical abuse perpetrated by a staff member (Staff J, Certified Nursing Assistant) toward two residents (#11 and #12) of seventy-four residents in the facility.</p> <p>On 12/20/2024, Staff J, Certified Nursing Assistant (CNA) was witnessed by Staff I, CNA slapping Resident #11 and Resident #12 on the legs, sides of their bodies, and buttocks during care. Staff I, CNA failed to report the abuse until three days after the event, leaving other facility residents at risk of further verbal and physical abuse.</p> <p>Findings included:</p> <p>Review of Resident #11's Admission Record showed the resident was admitted on [DATE] and had diagnoses including but not limited to unspecified quadriplegia, unspecified not intractable epilepsy without status epilepticus, sever intellectual disabilities, legal blindness as defined in USA, unspecified scoliosis, and gastrostomy status.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], showed Resident #11 had no speech, no Brief Interview of Mental Status (BIMS) score as the resident was rarely/never understood, had bilateral upper and lower extremity Range of Motion (ROM) impairments, and was dependent on staff for eating, hygiene needs, and mobility.</p> <p>Review of Resident #12's Admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record showed diagnoses including but not limited to sequelae traumatic subdural hemorrhage with loss of consciousness status unknown, sequelae diffuse traumatic brain injury with loss of consciousness of unspecified duration, unspecified psychosis not due to a substance or known physiological condition, generalized muscle weakness, and sequelae pedestrian on foot injured in collision with heavy transport vehicle or bus in traffic accident.</p> <p>Review of the quarterly MDS dated [DATE] showed Resident #12 had no speech, a BIMS score of 00, indicative of a severe cognitive impairment, no Range of Movement impairment, was dependent upon staff for hygiene needs, and required substantial/maximum assist for bed mobility. The comprehensive assessments showed the resident had been discharged with return anticipated on 12/25/2024 and returned on 12/29/2024.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/2/2025 at 10:22 a.m., a handwritten sign was observed posted inside the [NAME] wing nurses station showing [Resident #11] is on 15 min[ute] checks. When [Resident #12] returns [pronoun] is on 15 min[ute] checks as well. DO NOT STOP! - Management 12/27/24 Call on-call for any questions.</p> <p>An interview was conducted with Staff A, Registered Nurse (RN) on 1/2/2025. Staff A, RN observed the handwritten sign informing staff Resident #11 and Resident #12 were on 15-minute checks and reported having to clarify the 15-minute checks for Resident #11. The staff member removed the sign and folded it in half, saying it was out of date.</p> <p>An interview was conducted with the Nursing Home Administrator (NHA) on 1/3/2025 at 2:01 p.m. The NHA reported nurses were doing 15 minute checks on the two residents (#11 and #12) and reported an incident occurred on 12/20/2024. However, CNA did not report it until three days later on 12/24/2024 and the checks were started at that time. The NHA stated Staff I, CNA came to speak with the Staffing Coordinator and wanted to report an incident. The administrator stated Staff J, CNA was assisting Staff I, CNA with care for Resident #11 and Resident #12 and felt Staff J, CNA was rough while changing the residents. A review of employee statements was conducted with the NHA following the interview.</p> <p>Review of the statement made by Staff I, CNA on 12/23/2024 revealed on 12/20/2024, Staff J, CNA and Staff I, CNA were changing Resident #11 and Resident #12 and Staff J, CNA said the residents were combative. Staff I, CNA reported the residents were not being combative and Staff J, CNA slapped both of the residents' multiple times on the legs, sides of their bodies, and buttocks. Staff I, CNA reported a handprint was left on Resident #11. The staff member reported not saying anything about Staff J because they were scared due to past trauma (per NHA, was a personal incident) and did not want to be targeted. The witness statement revealed Staff I, CNA attempted to inform a nurse but could not find one. Instead, Staff I, CNA informed Staff K, Door Monitor, who informed Staff I, CNA of past instances of seeing Staff J, CNA pulling an unidentified residents hair and verbally abusing them, then added another resident seemed to have been scared of Staff J, CNA when the staff member was changing them.</p> <p>Review of a statement provided by Staff K, Door Monitor dated 12/23/2024 revealed on Friday 12/20/2024, an employee reported Staff J, CNA was being mean, rough, and hitting patients. Staff K, Door Monitor reported seeing Staff J, CNA previously pull a resident's hair and verbally abuse them by calling the resident's faggots and pieces of shit. Staff K, Door Monitor reported speaking with the 7 p.m. - 7 a.m. Registered Nurse (RN), who informed the staff member she had also heard of this, but the staff members chose not to say anything so as to not affect their jobs and prevent backfire on them. The NHA identified the 7 p.m. - 7 a.m. RN as Staff L, RN.</p> <p>Review of a statement dated 12/24/2024 from Staff L, RN revealed, I did not have any reports of any type of incident of abuse. The statement added Staff L, RN was unaware of the incident until questioned by a police officer.</p> <p>Review of Staff J, CNA's statement via email dated 12/24/2024 at 2:28 p.m. revealed, On the day in question I provided care to [Resident #11 and Resident #12], Bed A had a [bowel movement] which I changed him and my hall partner to help me pull him up in the bed.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During the interview and review of witness statements, the NHA stated the incident happened on 12/20/2024 and they would expect to be notified immediately. The NHA reported Staff J, CNA was suspended on 12/23/2024, who was later terminated, and interviews were started with Staff I, CNA and K, Door Monitor. The next morning, a statement was provided from Staff L, RN. The NHA reported law enforcement and state agencies were notified of the incident on 12/23/2024. The NHA stated based on information provided by Staff I, CNA and follow up from Staff K, Door Monitor, they believe the incident did occur. The NHA also stated they understood Staff I, CNA was new to the facility, but the residents are vulnerable adults and the facility has zero tolerance for abuse.</p> <p>Review of policy titled Abuse Prevention Program, revised August 2006, revealed the Policy Statement: our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. The Policy Interpretation and Implementation regarding Preventing Abuse showed: 1. Our facility is committed to protecting our residents from abuse by anyone including but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies providing services to our residents, family members, legal guardians, surrogates, sponsors, friends, visitors, or any other individual. The policy revealed under Abuse Prevention Program: 3. Comprehensive policies and procedures have been developed to aid our facility in preventing abuse, neglect, or mistreatment of our residents. Our abuse prevention program provides policy and procedures that govern, as a minimum:</p> <ul style="list-style-type: none"> a. Protocols for conducting employment background checks; b. Mandated staff training/orientation programs that include such topics as abuse prevention, identification, and reporting of abuse, stress management, dealing with violent behavior, or catastrophic reactions, etc; c. Identification of occurrences and patterns of potential of mistreatment/abuse; d. The protection of residents during abuse investigations; e. The development of investigative protocols governing resident abuse, theft/misappropriation of resident property, resident to resident abuse, and resident to staff abuse; f. Timely and thorough investigations of all reports and allegations of abuse; g. The reporting and filing of accurate documents relative to incidents of abuse; h. An ongoing review and analysis of abuse incidents; and i. The implementation of changes to prevent future occurrences of abuse. <p>The policy, under Assessment and Recognition, defines abuse as: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37999</p> <p>Based on interviews and record reviews, the facility failed to report an incident of verbal and physical abuse perpetrated by a staff member (Staff J, Certified Nursing Assistant) toward two residents (#11 and #12) of seventy-four residents in the facility.</p> <p>Findings included:</p> <p>Review of Resident #11's Admission Record showed the resident was admitted on [DATE] and had diagnoses including but not limited to unspecified quadriplegia, unspecified not intractable epilepsy without status epilepticus, sever intellectual disabilities, legal blindness as defined in USA, unspecified scoliosis, and gastrostomy status.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], showed Resident #11 had no speech, no Brief Interview of Mental Status (BIMS) score as the resident was rarely/never understood, had bilateral upper and lower extremity Range of Motion (ROM) impairments, and was dependent on staff for eating, hygiene needs, and mobility.</p> <p>Review of Resident #12's Admission Record showed the resident was admitted on [DATE] and readmitted on [DATE]. The record showed diagnoses including but not limited to sequelae traumatic subdural hemorrhage with loss of consciousness status unknown, sequelae diffuse traumatic brain injury with loss of consciousness of unspecified duration, unspecified psychosis not due to a substance or known physiological condition, generalized muscle weakness, and sequelae pedestrian on foot injured in collision with heavy transport vehicle or bus in traffic accident.</p> <p>Review of the quarterly MDS dated [DATE] showed Resident #12 had no speech, a BIMS score of 00, indicative of a severe cognitive impairment, no Range of Movement impairment, was dependent upon staff for hygiene needs, and required substantial/maximum assist for bed mobility. The comprehensive assessments showed the resident had been discharged with return anticipated on 12/25/2024 and returned on 12/29/2024.</p> <p>An interview was conducted with the Nursing Home Administrator (NHA) on 1/3/2025 at 2:01 p.m. The NHA reported nurses were doing 15 minute checks on the two residents (#11 and #12) and reported an incident occurred on 12/20/2024. However, CNA did not report it until three days later on 12/24/2024 and the checks were started at that time. The NHA stated Staff I, CNA came to speak with the Staffing Coordinator and wanted to report an incident. The administrator stated Staff J, CNA was assisting Staff I, CNA with care for Resident #11 and Resident #12 and felt Staff J, CNA was rough while changing the residents. A review of employee statements was conducted with the NHA following the interview.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the policy titled Reporting Abuse to Facility Management, revised February 2014, revealed the Policy Statement: It is the responsibility of our employees, facility consultants, attending physicians, family members, visitors, etcetera, to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The policy defined abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy showed under Responsibility of Person(s) Observing Incidents of Abuse: any staff member or person affiliated with this facility who has witnessed or who believes that a resident has been a victim of mistreatment, abuse, neglect, or any other criminal offense shall immediately report, or cause a report to be made of, the mistreatment or offense. Failure to report such an incident may result in legal/criminal action being filed against the individual(s) withholding such information. The policy also revealed under Notification of Administrator/DNS (DON) After Hours: The Administrator or Director of Nursing Services must be immediately notified of a suspected abuse or incidences of abuse. If such incidents occur or are discovered after hours, the Administrator and Director of Nursing Services must be called at home or must be paged and informed of such incident.</p>		