STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105350	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Haven Nursing and Rehab Center	1351 San Christopher Dr Dunedin, FL 34698

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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 - Some	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 interview and record review, the facility failed to provide wound care for three residents (#2, #3, and #4) of three residents reviewed. Findings included: Review of Resident #2's admission Record revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses to include unspecified injury at T11-T12 level of thoracic spinal cord, subsequent encounter, wedge compression fracture of lumbar vertebra, wedge compression fracture of thoracic vertebra, multiple myeloma not having achieved remission, and other co-morbidities. Resident #2 discharged to the hospital on 5/11/2025. Review of Resident #2's Medical Certification for Medicaid Long-Term Services and Patient Transfer Form (AHCA Form 3008) dated 4/30/2025 under the section titled Skin Care - Stage and Assessment revealed: 1. Left leg skin tear; 2. 4 punctures - spine status post (s/p) kyphoplasty; 3. RU (right upper) leg skin tear. Review of Resident #2's Specialty Physician Wound Evaluation & Management Summary dated 5/6/25 revealed: Site 1, Skin tear wound of the Left, distal shin full thickness, duration greater (>) than 26 days, wound size (Length x Width X Depth): 3.2 x 0.8 x 0.1 centimeters (cm); exudate: Light Serous; Slough: 50%, granulation tissue: 50%. Treatment Plan: Xeroform Gauze Dressing (a gauze of fine mesh impregnated with petrolatum and 3% Bismuth Tribromophenate), apply three times per week and as needed; and [Brand Name] gauze roll 4.5 apply three times per week and as needed, Tape for retention apply three times per week and as needed. Site 2, Skin tear wound of the Right, dorsal forearm, full thickness, duration >1 days, wound size (L x W x D): 7 x 5 x 0.1 cm, exudate: Light Serous, granulation tissue: 100%. Treatment Plan: Xeroform gauze apply three times per week and as needed, and [Brand Name] gauze roll 4.5 apply three times per week and as needed and tape for retention apply three times per week and as needed. Review of Resident #2's physician order summary report revealed an ordered dated 5/7/2025, cleanse skin tear to Left (L) shin with wound cleanser, dry, apply Xeroform, and wrap with [Brand Name] gauze roll 4.5, three times per week and as needed.; Cleanse skin tear to Right (R) forearm with wound cleanser, dry, apply Xeroform, and wrap with [Brand Name] gauze roll 4.5 three times per week and as needed; and tape for retention three times per week and as needed. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's Treatment Administration Record (TAR) for May 2025 revealed no skin care orders prior to 5/7/2025 and the treatment for the left shin and right forearm occurred only on 5/10/2025 during the resident's stay. During an interview on 6/11/2025 at 10:21 a.m., the resident's responsible party (RP) stated visiting Resident #2 daily while in the facility. The RP said the facility did not provide consistent wound care for Resident #2 during the stay. During an interview on 6/11/2025 at 4:54 p.m., Staff A., Licensed Practical Nurse (LPN) and Unit Manager (UM) stated Resident #2 required wound care treatments throughout his stays at the facility and was unsure why the orders were not implemented on admission. Review of the admission Record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses to include osteomyelitis of vertebra, sacral and sacrococcygeal region, pressure ulcer of right buttock, resistance to vancomycin, methicillin resistant staphylococcus aureus, and other co-morbidities. Review of Resident #3's AHCA form 3008 dated 5/15/25 revealed: Left foot (plantar) wound care, cleanse wound (and pat dry) with normal saline wound cleanser, apply skin barrier to peri-wound: to wound of left foot (plantar), cleanse wound, pat dry, paint with betadine, leave open to air and change every 12 hours. Wound care, sacrum, cleanse wound (and pat dry) with wound cleanser, apply dressing with [brand name], apply dressing with gauze 4x4, bordered gauze; right and left ischial tuberosity, cleanse wounds, pat dry, apply [brand name] to wound bed and undermining, cover with gauze and [brand name] dressing, twice a day (bid). Review of Resident #3's Nursing admission Screening/History dated 5/17/205 at 12:58 a.m., revealed under the Skin section: unstageable pressure area to right toe(s), Stage IV pressure area to sacrum, Stage III pressure area to left gluteal fold, and Stage III pressure to the right gluteal fold. Review of Resident #3's Specialty Physician Wound Evaluation & Management Summary dated 5/20/25 revealed: - Site 1: Stage 4 Pressure wound sacrum full thickness, noted present on admission, wound size (L x W x D): 8.5 x 12.5 x 1 cm, undermining 2.5 cm at 5 o'clock; exudate: moderate serous, granulation tissue 70%; other viable tissues: 30% (muscle, fascia, bone), Treatment: collagen powder apply once daily and as needed, if saturated, soiled, or dislodged. Alginate calcium apply once daily and as needed, cover with island gauze with border once daily. - Site 2: Stage 4 Pressure wound of the Left Ischium Full thickness, noted present on admission, wound size: 6.5 x 5.5 x 1 cm, undermining 1 cm at 9 o'clock; exudate: moderate serous; slough 20%; granulation tissue: 60%; other viable tissues: 20% (muscle, fascia, bone), Treatment: collagen powder apply once daily and as needed, if saturated, soiled, or dislodged. Alginate calcium apply once daily and as needed, cover with island gauze with border once daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Site 3: Stage 4 Pressure wound of the right ischium full thickness noted present on admission, wound size 7.0 x 3.5 x 2 cm; undermining: 0.5 cm at 5 o'clock; exudate: moderate serous; slough 20%; granulation tissue: 70%; other viable tissues: 10% (muscle, fascia, bone), Treatment: collagen powder apply once daily and as needed, if saturated, soiled, or dislodged. Alginate calcium apply once daily and as needed, cover with island gauze with border once daily. - Site 4: Unstageable (due to Necrosis) of the left foot full thickness noted to be present on admission; wound size 2.3 x 1.7 x not measurable cm; 100% thick adherent black necrotic tissue (eschar): Treatment: betadine apply once daily for 30 days. Recommendations: low air loss Mattress, upgrade off-loading chair cushion, Vitamin C 500mg BID (twice daily) and Zinc Sulfate 220mg daily for 14 days. Review of Resident #3's physician order summary report revealed: 1. 5/17/25 consult wound care; 2. 5/21/25 cleanse bilateral ischium (buttock folds) wounds with wound cleanser, dry, apply collagen powder, apply calcium alginate, and finish with bordered gauze dressing daily and as needed for if soiled or dislodged. 3. 5/21/25 cleanse bilateral ischium buttock fold wounds with wound cleanser, dry, apply collagen powder, apply calcium alginate, and finish with bordered gauze dressing daily. 4. 5/21/25 Cleanse sacral wound with wound cleanser, dry, apply collagen powder, apply calcium alginate, and finish with bordered gauze dressing daily. 5. 5/21/25 Cleanse sacral wound with wound cleanser, dry, apply cotton allergen powder, apply calcium alginate and finish with bordered gauze dressing daily. Review of Resident #3's facility record lacked documentation of wound care until 5/21/25. Review of Resident #4's admission Record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses to include end stage renal disease, and other co-morbidities. Review of Resident 4's AHCA form 3008 dated 6/7/25 revealed unstageable sacrum, coccyx wounds x 2, 2 ulcers on the midline back. Review of Resident #4's Nursing admission Screening/History dated 6/10/205 at 16:35 (4:35 p.m.). revealed under the Skin section: unstageable pressure to the Vertebrae (upper-mid); Unstageable wound on coccyx; Unstageable wound on coccyx; unstageable wound to sacrum; and unstageable wound to sacrum; treatment ordered or required is marked. Review of Resident #4's physician order summary lacked any wound care orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/25 at 11:15 a.m. Staff B, LPN stated when a resident was admitted to the facility an admission evaluation was completed. The evaluation included completing a head to toe skin evaluation. If the skin had any marks, breaks or abnormal openings, these openings would be indicated on the evaluation. The nurse would notify the physician and obtain orders for treatment of these skin impairments, as well as wound care consult. During an interview on 6/12/25 at 11:20 a.m., Staff C, LPN stated upon a resident's admission an evaluation of their skin was completed for any breaks or bruises. The nurse contacts the physician and obtains orders for treatment to the areas. During an interview on 6/12/25 at 11:46 a.m., the Director of Nursing (DON) said the expectation for the nurses upon a resident's admission was to complete a full Nursing admission Evaluation which included a complete evaluation of the resident's skin. If the nurse noticed any skin issues the nurse should notify the physician to obtain orders to treat the area. The DON reviewed the following documentation: -Resident #2's TAR and confirmed no orders were obtained until 5/7/2025 and the 3008 indicated the skin issues on the form at admission. -Resident #3's Nursing admission assessment dated [DATE] showed: sacral, left and right gluteal fold, and area on the foot and confirmed admission orders were only received for the foot and sacrum not the left and right gluteal folds. -Resident #4's 3008 revealed resident was admitted for wound care, unstageable pressure ulcers to the: sacrum, left and right coccyx , and two ulcers to to the mid back and the facility TAR lacked orders for any wound care. The DON stated the expectation was not met for Residents #2,3, and 4. Review of the facility's policy and procedure titled, Skin and Wound with a revision date of 9/24/2024 revealed: Policy: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of pressure injury. Procedure: * on admission/readmission the resident's skin will be evaluated for baseline skin condition and documented in the medical record . *Licensed nurse to complete skin evaluation weekly and prior to transfer/discharge and document in the medical record .*Provide treatment per physician order with documentation in the medical record. QAPI: Patterns and trends of newly developed and/or worsening skin conditions will be reviewed by the QAPI team.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interviews, the facility did not ensure medical records were completed and accurate for one resident (#2) out of three sampled residents. Findings included: Review of admission Records showed Resident #2 was admitted to the facility from the hospital on 5/2/25 and discharged from the facility on 5/11/25. On 6/11/25 at 10:30 a.m. Resident #2's Nursing admission Screening/History, dated 5/2/25, was reviewed. The Nursing admission Screening/History was blank with the exception of the vitals signs that auto populate when the documented is initiated. There was no documentation under the sections for admission details, level of consciousness/orientation/neurological, social history/lifestyle concerns, general appearance, HEENT (head, eyes, ears, nose throat), respiratory/chest, cardiac/circulation, GI (gastrointestinal)/bowel, GU (genitourinary)/bladder, extremities/gait/mobility, skin, ADL's (activities of daily living)/functional devices, other relevant diagnoses/concerns, pain, and medications. On 6/11/25 at approximately 12:45 p.m. a request was made to the Chief Nursing Officer (CNO) to print Resident #2's Nursing admission Screening/History, dated 5/2/25. The CNO was notified the assessment was not completed. On 6/11/25 at 4:45 p.m. a printed copy of Resident #2's 5/2/25 Nursing admission Screening/History was provided. At that time the assessment was observed to have all sections fully completed. Upon review of the electronic medical record it was noted the assessment had been locked on 6/11/25 at 4:37 p.m. by Staff A, Licensed Practical Nurse (LPN)/Unit Manager (UM). An interview was conducted on 6/11/25 at 4:54 p.m. with Staff A, LPN/UM. When asked about Resident #2's Nursing admission Screening/History from 5/2/25 Staff A immediately put her head down and her shoulders slumped. Staff A said she noticed the assessment had not been completed so she filled it out today, 6/11/25. She said she was not the nurse that did Resident #2's admission. She said the nurse that did the admission assessment no longer worked at the facility. Staff A said she did remember looking at the resident every day when she came in. Staff A said she did not know why the admission assessment was not completed. She said she normally did not go in and fill out documentation late, especially for things she did not do herself. When asked what made her look at Resident #2's Nursing admission Screening/History on 6/11/25, she said they requested I look at it. When asked whom she was referring to, Staff A stated the CNO went to her and asked her to make sure everything is there and good on Resident #2's 5/2/25 admission assessment. Staff A said she knew she should not have completed the documentation when she didn't do the assessment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 6/12/25 at 1:47 p.m. with the facility's CNO. The CNO said there was a list of assessments and documents the admitting nurse should complete when a resident is admitted to the facility. She confirmed this included the Nursing admission Screening/History. She said when the Nursing admission Screening/History is completed, it should be signed and locked. She said if is not locked by the nurse it will stay in progress. She said if someone else noticed it wasn't locked and locked the document for the nurse, that person should not change or add any documentation. She said she expected if a nurse started an assessment, they should finish it, sign it, and then lock it. In regard to Resident #2, the CNO said she asked Staff A, LPN/UM to help her print the documents that had been requested. She said she did not remember being told the 5/2/25 Nursing admission Screening/History for Resident #2 was blank, but she should have been notified. The CNO said she was trying to do multiple things. She said the assessment should have been fully completed when Resident #2 was admitted on [DATE]. She said nurses were not supposed to enter information if they were not there, even if they knew the resident. She said her expectation was that all documentation should have been completed within 72 hours at the most. She said if it was more than 72 hours after admission and an assessment was not fully completed, she would expect the nurse to print the incomplete documentation and scan it into the miscellaneous section of the medical record, then start a new assessment and complete it. The CNO said the only documentation that should be put in a resident record after they are discharged would be a recap of the resident's stay if that is needed. The CNO confirmed Resident #2 was discharged from the facility on 5/11/25, one month prior to the Nursing admission Screening/History being completed and locked. The CNO reviewed Resident #2's 5/2/25 Nursing admission Screening/History and confirmed it was locked on 6/11/25 by Staff A, LPN/UM. The CNO said Staff A, LPN/UM should not have completed the documentation. The CNO said she did not ask Staff A to look at Resident #2's assessment and complete it. The CNO stated the facility did not have a policy documentation of admission assessments. Review of a facility policy titled Ethics, revised 12/11/24 showed under policy: It is the policy of [Corporation name] that all employees are governed by the Company's Policies and Procedures and shall conduct company business in a manner which is at all times legal, ethical and integral and in alignment with as outlined by the corporate officers. The procedure showed: The employee handbook provides general guidelines for employees in order to meet the highest standards of business conduct as set forth in the policy statement above.