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	06/11/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to ensure advanced directives were implemented as requested for one resident (#2) out of three reviewed.Findings included: Review of admission Records showed Resident #2 was admitted on [DATE] with diagnoses including cirrhosis of liver, thrombocytopenia, chronic obstructive pulmonary disease, and hepatic encephalopathy. Review of Resident #2's orders showed an active order for Full Code, dated 4/19/26. Review of Resident #2's medical record revealed a signed Do Not Resuscitate (DNR) order signed by the resident's healthcare surrogate on 5/7/26. The DNR was not signed by a provider until 5/26/26. Review of the DNR books at the nurses' stations did not show a DNR form for Resident #2. An interview was conducted on 6/1/26 at 4:14 p.m. with Staff A, Licensed Practical Nurse (LPN). Staff A said she was assigned to care for Resident #2. Staff A said if a resident were to go into cardiac arrest she would check the resident's orders and the DNR book to confirm their code status. Staff A verified Resident #2 had an active full code order, and he did not have a DNR form in the DNR book. Staff A said Resident #2 was a full code. An interview was conducted on 6/1/26 at 3:50 p.m. with the Social Services Director (SSD). The SSD said when a resident on hospice changes their code status, the hospice vendor completes the paperwork. The SSD reviewed Resident #2's signed DNR form and confirmed that a hospice provider signed the form. The SSD said she didn't know why there was a 19-day gap in the healthcare surrogate signing the DNR form and the provider signing the form. She said usually they both sign on the same day. She said she did not know who brought the form to the facility or who it was given to. The SSD said I think it gets lost in translation when hospice does it regarding putting DNR orders in the medical record and the form in the DNR book. The SSD reviewed Resident #2's medical record and confirmed Resident #2 had an active full code order. An interview was conducted on 6/1/26 at 4:19 p.m. with the Director of Nursing (DON). The DON confirmed Resident #2 did not have a signed DNR form in the DNR books. She reviewed the signed DNR from the medical record and said Resident #2's orders should have been updated and a copy of the DNR form should have been placed in each DNR book. An interview was conducted on 6/1/26 at 4:25 p.m. with the Nursing Home Administrator (NHA). The NHA said they do weekly audits for code status but Resident #2's might not have been caught on the audit because the full code order in the medical record matched what was in the DNR books. The NHA confirmed not reviewing the medical chart during the audits. Review of a facility policy titled Advanced Directives, revised 2/28/24, showed:Policy:The center will abide by state and federal laws regarding advance directives. The center will honor all properly executed advance directives that have been provided by the resident and/or resident representative.Procedure:2. If an advance directive exists, the Social Services and/or Business Development Coordinator/designee will obtain a copy and place it in the resident's medical record.3. If the resident has not executed an advance directive but wishes to establish an advance directive, Social Services/designated center representative will assist the resident/ resident representative with obtaining the state approved advance directive documents. Formulating an advance directive is the choice of the resident and is not required.4. Upon completion of Advanced Directives Discussion (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Document, Social Services or nurse will notify thePhysician of the resident's wishes and procure a state approved Do Not Resuscitate Order, if necessary. Notification will be documented in the medical record.5. Advanced Directives will be reviewed: Quarterly Hospice admission Additional times as need or requested by the resident/resident representative,Reviews are designed to: Identify and clarify the content and intent of the existing care instructions, and whether the resident wishes to change or continue these instructions Identify situations where health care decision-making is needed. Review the resident's condition, mental capacity to make health care decisions, and existing choices and continue or modify approaches Any changes to advanced Directives will require the previous document to be filed in the thinned record.5. Upon notification from resident and/or resident representative of the desire to change or revoke an advance directive, or any issue concerning the capacity, the physician will be notified, and the medical record will be modified accordingly.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations and interviews, the facility did not ensure adequate supply of linens for two (100 and 200) out of three units in the facility.Findings included: An observation was conducted on 6/1/26 at 9:10 a.m. of the linen closet on the 100 unit. There were no towels or washcloths in the closet. An interview was conducted on 6/1/26 at 1:45 p.m. with Resident #8. She said there is a problem with having towels and washcloths. Resident #8 stated when they do get towels, they are very rough. Resident #8 said she could shower herself but often had to wait because there were no towels available. An interview was conducted on 6/1/26 at 5:11 p.m. with Resident #7. Resident #7 stated on multiple occasions that towels were not available for showers. Resident #7 said it would be nice to have towels when showering. An interview was conducted on 6/1/26 at 12:56 p.m. with Staff E, Certified Nursing Assistant (CNA). She said there were concerns regarding having linens available for residents, specifically towels. She said often residents had to wait to receive showers until towels were available. Staff E said many residents complained about the towels and described them as feeling like sandpaper. She said residents sometimes need to be cleaned and ask if they can use sheets, so they don't have to wait on towels. Staff E said some staff have used sheets to clean residents. An interview was conducted on 6/1/26 at 4:36 p.m. with Staff G, CNA. Staff G said she worked on the 200 unit and had concerns about having supplies available. Staff G said the unit intermittently had towels available and often did not have wipes to use in place of towels to clean residents. Staff G said she knew there had been issues with laundry equipment and staffing and more support was needed to maintain the supplies. An interview was conducted on 6/1/26 at 5:28 p.m. with Staff D, CNA. Staff D was observed in the linen closet on the 100 unit looking for towels and washcloths. Staff D said she did not have any towels or washcloths available and it was always a problem. She said it makes it difficult to clean residents and get resident showers completed because there are no towels and no wash clothes or wipes to clean residents. An interview was conducted on 6/1/26 at 1:35 p.m. with Staff C, Laundry. Staff C said she delivered clean linen to the units about five times a day and divides them between the units based on where more residents are. Staff C said the facility did not have an extra supply of linens or towels beyond those that were in circulation currently. An interview was conducted on 6/1/26 at 2:29 p.m. with the Housekeeping Director. He said he is new to the facility, but is responsible for ordering linen, washcloths, and towels. He also noted one of the facility dryers was broken and in the process of being repaired. On 6/1/26 at 5:55 p.m. the Director of Nursing said the facility did not have a policy regarding linens or supplies on the units.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to fully implement its abuse prevention policy by not preventing Resident #11 from further accessing alleged victims and by not implementing effective interventions to protect other residents from additional abuse for two residents (#9 and #12) of three residents sampled.Findings included: During an interview on 6/11/26 at 1:22 p.m., the facility's psychiatric ARNP (advanced registered nurse practitioner) reported she saw Resident #11 weekly due to behavioral concerns. She stated on 4/23/26, she evaluated him after staff reported he had touched another resident inappropriately. At that time, he had been placed on 1:1 supervision two days earlier. The ARNP stated a CNA (Certified Nursing Assistant) witnessed Resident #11 groping Resident #12, who was his roommate. Both residents were assessed and then placed on 1:1 supervision together in the same room. The ARNP said that on 5/22/26, staff contacted telehealth to report a second incident involving Resident #11, during which a staff member observed him exposing himself to Resident #9. After this second incident, Resident #11 was moved to the semi^locked unit due to sexual attempts. She stated Resident #11 did not understand his actions due to dementia. The ARNP reported his medications were increased, he was placed on estrogen to decrease libido, and monitoring was increased. She stated he had a fixation on male residents, was confused, and both alleged victims were impaired. The ARNP confirmed Resident #11 had been on 1:1 supervision, but it was discontinued at some point and replaced with 15^minute checks; the second incident occurred during the period he was not on 1:1 supervision.On 6/11/26 at 10:28 a.m., an interview with Staff H, Licensed Practical Nurse (LPN), and Staff I, CNA, revealed they were not working at the time of the event but had heard about a situation involving Residents #11 and #9. Staff I reported, I heard the two men were found ?doing it.' Staff H stated Resident #9 was confused and would not know what was going on. Staff H stated Resident #11 was the one acting out sexually toward Resident #9. Staff I stated this occurred about a month before the interview; both men were on the same wing but not in the same room. She also reported that Resident #9 was later moved to the secured unit.On 6/11/26 at 11:15 a.m., an interview was conducted with Staff J, CNA who was observed providing 1:1 supervision to Resident #11. She stated the 1:1 supervision began the last week of May due to an incident that happened about 3 weeks earlier. She reported hearing that Resident #11 had groped a male resident. Staff J stated Resident #11 wandered, posed safety concerns, and needs supervision. She explained that he was directed to men and had been trying to touch male residents for some time.On 6/11/26 at 11:20 a.m., an attempt to interview Resident #11 was unsuccessful. He appeared drowsy and did not open his eyes.Record review for Resident #11 indicated an admission date of 4/20/26 with diagnoses including dementia, mood disorder, major depression, and a right femur fracture. A 4/20/26 psychiatry evaluation documented staff reports of yelling, grabbing, and inappropriate touching; he was placed on 1:1 observation.A 4/21/26 APRN note documented concerns for potentially touching another resident inappropriately; he was moved to the secured unit for wandering. A 4/22/26 behavior note documented that he attempted to grab another male resident's genital area and was redirected by his 1:1 CNA.A 4/28/26 H&P (history and Physical) noted continued reports of inappropriate touching. A 5/4/26 APRN note documented he was still on 1:1 supervision, with a plan to discontinue it and initiate 15^minute checks. A 5/7/26 APRN note documented he was observed touching another patient sexually and the residents were separated. A 5/12/26 progress note documented ongoing inappropriate sexual behavior; Resident #11 stated he was helping people.A 5/8/26 BIMS score for Resident #11 was 11, indicating moderate impairment. Staff reported disruptive and hypersexual behaviors.A 5/22/26 nursing note documented that a CNA observed him in the wrong room allegedly touching another resident, and he was placed on 1:1 supervision. A 5/22/26 psychiatry note documented continued sexually inappropriate behaviors, posing significant safety concerns.A care plan initiated 4/21/26 listed interventions including 1:1 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision as much as possible. The care plan was not updated following the second incident on 5/22/26.Record Review for Resident #12 revealed he was admitted on [DATE] with dementia, mood disorder, psychotic disorder, and depression. A 4/21/26 psychiatry note documented he was evaluated for suspected inappropriate touching by another resident; he did not recall the incident.A 4/28/26 follow^up note documented he was pleasantly confused and stable. A 5/7/26 thirty^day follow^up documented he had been separated from Resident #11 and moved to another room. He was unable to recall events and had no reported pain.On 6/11/26 at 11:20 a.m., Resident #12 did not respond to interview attempts. Staff L (LPN) described him as confused, quiet, and keeping to himself. Staff K stated, I don't believe he would grope anybody.On 6/11/26 at 10:30 a.m. on 6/11/26, Resident #9 was observed lying in bed, confused, and unable to participate in an interview. Family members present stated he had recently been moved to the secured unit for his safety. They stated he complained of pain two days after the move and were unsure if the pain was related to a physical encounter because he was severely confused.Resident #9 was admitted on [DATE] with diagnoses including Alzheimer's disease, aphasia, mood disorder, major depression, hallucinations, and suicidal ideation. A 4/28/26 neurology note documented he was disoriented, mostly non^verbal, and unable to answer questions. A 5/22/26 psych note documented he did not recall the incident and stated he felt good. A 5/26/26 acute care note documented he had been involved in unwanted sexual behavior by another resident but had no noted physical or psychosocial harm.On 6/11/26 at 1:17 p.m., an interview was conducted with the Social Services Director (SSD) who reported she only updated admission goals and smoking^related care plan sections and did not update care plans related to behavior concerns. She stated she did not know why the care plan listed 1:1 supervision as much as possible, explaining she believed 1:1 should mean continuous supervision. She explained the MDS nurse updated behavioral care plans; however, that nurse was unavailable for interview.While reviewing Resident #11's 15^minute check sheets (4/22-6/9) with the Director of Nursing (DON) on 6/11/26 at 4:13 p.m., multiple missing entries were noted, including entire shifts and full days. The DON stated she was overwhelmed, lacked unit managers, and could not verify that 1:1 supervision occurred. She said missing documentation meant the monitoring didn't happen. She confirmed the skin assessment for Resident #9 was not completed until four days after the incident and stated assessments following allegations should occur immediately.During an interview conducted with the NHA on 6/11/26 at 4:54 p.m., the NHA stated the facility did not separate the residents after the first incident; both residents remained in the same room on 1:1 supervision. He stated Resident #12 was not moved until 5/7/26, 16 days later, due to limited space. He stated Resident #11 was moved on 5/12/26. The NHA acknowledged missing and falsified check sheets, stating the repeated signatures were due to staff laziness. He stated he expected staff to provide continuous eyes^on 1:1 supervision and notify him of concerns.On 6/11/26 at 5:18 p.m., the NHA stated that on 5/22/26, a CNA found Resident #11 in the wrong room with his private area exposed toward Resident #9. He stated the skin assessment completed on 5/26/26 was not timely. He reported Resident #11 was taken out of the facility and later returned. Police were present during the investigation. He stated the CNA involved later recanted and was suspended for not cooperating. The NHA stated no physical harm had been identified but could not speak to psychosocial impact. He stated missed supervision may have contributed to the second incident.During the interview on 6/11/26 at 1:22 p.m. with the facility's psych ARNP, she stated all three residents were severely impaired and that there was no evidence of psychosocial impact, though she acknowledged it was difficult to determine. She stated Resident #11 was redirectable and did not discuss the incidents. The ARNP said, They are all confused and severely impaired. Hard to rule out psychosocial impact, but it was not evident.Review of a facility policy titled, Abuse Prevention Program, Revised 2006, revealed a policy statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion.Policy Interpretation and Implementation:I. Our facility is committed to protecting our residents from abuse by anyone including but not necessarily limited to: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility staff, other residents. or any other individual.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 policies and procedures that govern as a minimum: c. Identification of patterns of potential mistreatment/abuse. Timely and thorough investigations of all reports and allegations of abuse. h. An ongoing review and analysis of abuse incidents and i. The implementation of changes to prevent further occurrences of abuse.

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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, record review, and interviews the facility failed to assess and monitor one (Resident #10) of one resident following an off-campus accident resulting in a transfer to an acute care facility by emergency services for examination and testing.Findings included: An observation on 06/11/2026 at 12:06 p.m. showed Resident #10 sitting in wheelchair in the resident's room. The resident was alert and oriented during the observation and interview. Resident #10 reported sometimes having a different kind of stabbing pain. The resident reported being hit by a car in the parking lot of the store across the street from the facility while sitting in the wheelchair. Resident #10 reported grabbing the wheelchair frame under and slightly in front of the armrests while the car hit the side of the chair. The resident did not fall out of the chair and was transferred to the acute care facility by emergency services. Resident #10 stated upon returning to the facility, everyone asked me how I was. Resident #10 stated feeling scared, nervous, and frightened now about potentially falling out of the chair. Review of Resident #10's admission Record showed the resident was admitted on [DATE] with diagnosis not limited to type 2 diabetes mellitus with diabetic autonomic (poly) neuropathy and other intervertebral disc degeneration lumbar region with discogenic back pain and lower extremity pain. Review of Resident #10's progress notes revealed the following:6/4/26 effective 11:00 a.m., nursing note: pt (patient) signed out LOA (leave of absence) to go to [name of store].6/4/26 effective 11:20 a.m., nursing note: received notification that pt was struck by motor vehicle while in [name of store] parking lot. Paramedics [sic] with pt face sheet and med list given to paramedics.6/4/26 effective 4:38 p.m. nursing note from Registered Nurse (RN): Resident educated on the importance of safety and being aware of surrounding when out of the facility on independent LOA. Resident voices understanding. The resident received one tablet of Oxycodone-Acetaminophen 10-325 milligram (mg) on 6/4/26 at 4:33 p.m. per every 6 hours as needed (prn) physician order.6/4/26 effective 5:15 p.m. nursing note: md [medical doctor] notified new order received for no LOA till evaluated by MD.6/4/26 effective 5:58 p.m. nursing note: received call from [acute care facility] regarding CT [computed tomography] results. There is no FX [fracture] of the pelvis, previous x-ray stated possible. Per CT no FX.6/4/26 at 9:24 p.m. The resident's dose of Oxycodone-Acetaminophen was unknown. The same nurse documented at 10:30 p.m. another dose for leg pain. The staff documented the dosage was effective at 11:32 p.m.The review revealed no other progress notes were completed for the resident on 06/04/2026 by any staff member. Review of Resident #10's assessments revealed no assessments were completed for Resident #10 from 06/1/2026 to 06/08/26, three days prior to the accident and four days after the accident. A skin evaluation was completed on 06/08/2026, four days after the accident. Review of Resident #10's June 2026 Medication Administration Record (MAR) revealed daily vital signs were scheduled once a day at 6:00 a.m.Morphine Sulfate Extended Release 15 mg - one tablet by mouth every 12 hours for chronic pain. Hold for sedation, systolic blood pressure (SBP) less than 110, heart rate (hr) less than 60, oxygen (O2) saturation (sat) less than 90%. The administration was scheduled for 9:00 a.m. and 9:00 p.m. Oxycodone - Acetaminophen 10-325 mg - one tablet by mouth every 6 hours as needed for moderate to severe pain until 6/9/26 at 11:59 p.m. Hold for sedation, SBP less than 110, HR less than 60, O2 sat less than 90%. The documentation showed the blood pressure, pulse, O2, and pain level were taken at 4:33 p.m. and 10:30 p.m. to correspond with the administration of the medication. The MAR showed the medication was administered at 10:30 p.m. for a pain level of 0. An interview was conducted with Social Service Director (SSD) on 06/11/2026 at 10:12 a.m. The SSD reported Resident #10 was hit by a car in the parking lot of the store across the street (from facility). The resident was alert and oriented with no behavioral issues. The SSD reported not speaking with the resident after the incident and agreed the incident could have been traumatic. During a continued interview with the Director of Nursing and the SSD at 10:22 a.m. the SSD reported doing a Brief Interview of Mental Status assessment quarterly, a trauma-centered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post Traumatic Stress Disorder (PTSD) assessment only at admission and did not have any other assessment to complete. The DON stated psychiatry came in weekly to see the resident. An interview was conducted with the Medical Director on 06/11/2026 at 10:48 a.m. The MD reported an accident, which occurred with Resident #10, could have caused psychosocial and trauma however when the MD spoke with the resident on Friday (06/05/2026) the resident did not express any concerns at that time. During an interview on 06/11/2026 at 11:41 a.m. the Director of Nursing stated when a resident returns from the hospital, the facility staff need to do a re-admission assessment, even when the resident doesn't spend the night, if the resident was gone less than 24 hours staff still do a re-admission, and if a resident goes out to the hospital for a couple of hours staff are supposed to do a re-admission assessment. The Director of Nursing reviewed Resident #10's assessments and pointed out a skin evaluation created on 06/01/2026 (three days prior to the incident) and which was locked on 06/05/2026 (the day after incident). The DON then stated a re-admission assessment was only done if a resident came back from the hospital with new orders. The DON stated an evaluation was to be completed by staff when a resident returned (from hospital), the staff was to check vital signs which included blood pressure, pulse, respirations, temperature, and oxygen level, evaluate pain, complete a skin assessment, verify medical orders, and notify family and physician. The DON reviewed the resident's chart and stated the nurses did not do a skin assessment upon the resident's return and (staff could) do better. An interview was conducted with the Assistant Director of Nursing on 06/11/2026 at 4:45 p.m. The assistant reported there were no assessments done on 06/04 and 06/05/2026 for Resident #10. An interview was conducted with the Nursing Home Administrator (NHA) on 06/11/2026 at 4:52 p.m. The NHA stated staff should be doing an assessment when a resident comes back from the hospital after being hit by a car. The NHA reported the facility did not have a policy regarding a resident returning from the hospital.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to reevaluate and reassess interventions to prevent falls for one resident (#2) out of three reviewed. This resulted in Resident #2 sustaining a head laceration and transfer to acute setting for further evaluation. Findings included: Review of the facility's Incident Log showed Resident #2 had falls on 4/15/26 and 5/10/26. Review of Resident #2's progress noted showed:5/8/26 5:20 p.m. Patient found after unwitnessed fall with noted head injury. No acute distress noted. Upon assessment, light bleeding noted to head. Patient alert and responsive. Vital signs obtained and within normal limits (WNL). Provider notified of findings and new orders received for Computed Tomography (CT) scan. Patient transferred for CT scan per provider order. 5/10/16 10:47 a.m. Resident was noted to have an unwitnessed fall. Resident was observed lying on the floor, alert and at baseline mental status. Bleeding noted to the right side of the head. First aid was administered and vital signs were obtained. 911 was called for further evaluation and treatment. NP (Nurse Practioner) notified and responsible party (RP) made aware. Review of admission Records showed Resident #2 was admitted on [DATE] with diagnoses including encephalopathy, nontraumatic subarachnoid hemorrhage and unspecified symbolic dysfunctions. Review of Resident #2's Care Plan showed a focus area of risk for falls and fall related injuries r/t [related to] dx [diagnosis] of hepatic encephalopathy, BIMS [Brief Interview for Mental Status] score of 99 [indicating interview was unable to be completed], schizophrenia, and bipolar disorder. Revised on 2/20/26.Interventions included:-Bed in lowest position. Date Initiated: 2/12/26-Observe for and report changes in mobility and/or Range of Motion. Date Initiated: 2/12/26-Call bell in reach. Date Initiated: 2/12/26-Assist as needed with transfer/ambulation. Date Initiated: 2/12/26-Toilet before and after meals. Date Initiated: 2/17/26-Monitor blood glucose per orders. Date Initiated: 2/20/26-Ensure appropriate footwear worn. Date Initiated: 3/6/26-PT [physical therapy] evaluation. Date Initiated: 4/20/26-Mat on side of bed, therapy screen. Date Initiated: 4/20/26-Review of medications. Date Initiated: 4/20/26-Q15 minute check as ordered. Date Initiated: 5/5/26-Transfer/Gait belt for transfers and/or ambulation. Date Initiated: 5/11/26 The Care Plan did not show any updates or added interventions after the fall on 5/8/26. An interview was conducted on 6/1/26 at 3:17 p.m. with the Director of Nursing (DON). The DON said she did not know anything about Resident #2 having a fall on 5/8/26. She reviewed Resident #2's medical record, read the progress note about the resident's fall on 5/8/26 and confirmed a change of condition was not completed and there were not any records from the CT scan or the resident returning to the facility. The DON said Resident #2 had a fall on 5/10/26 that caused bleeding to the right side of his head, and he went to the hospital. An interview was conducted on 6/1/26 at 4:27 p.m. with the Regional DON. He said the expectation was that when a fall occurred, a change of condition be completed, the fall would be reviewed at the interdisciplinary team (IDT) meeting, and the resident's care plan would be updated with new interventions. The Regional DON reviewed Resident #2's medical record and said he did not see care plan updates, added interventions, or any information related to the fall on 5/8/26 except the progress note stating there was a fall that occurred. He confirmed the resident fell again on 5/10/26. An interview was conducted on 6/1/26 at 6:22 p.m. with the Nursing Home Administrator (NHA). He said he did not know what happened with Resident #2's fall on 5/8/26 and was not sure why it was not reviewed. He said on 5/11/26 the IDT reviewed Resident #2's fall on 5/10/26 but missed the fact Resident #2 had a fall on 5/8/26 as well. The NHA said the 5/8/26 fall should have been reviewed, and nursing staff should have put interventions in place immediately after that fall to prevent Resident #2 from falling again on 5/10/26. Review of a facility policy titled Falls, revised 2/11/26, showed:Overview:Patient centered interventions are initiated, based on resident risk. A fall refers to unintentionally coming to rest on the ground, floor, other lower level or an overwhelming external (continued on next page)

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	06/11/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred.Policy:Is to identify residents at risk for falls and establish/modify interventions to decrease the risk of a future fall(s) and minimize the potential for a resulting injury.B. Fall Mitigation Strategies:1. Develop resident centered interventions based on resident risk factors2. Update the resident's care plan with interventionsC. Post Fall Strategies:1. Resident will be evaluated, and post fall care provided as indicated2. Initiate Neurological checks as per physician order3. Notify the Physician and resident representative4. Update Care plan with intervention(s)