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	06/30/2026

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

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents' right to retain and use their personal possessions. The facility did not return or replace missing personal items for two residents (Rooms #127ˆW and #111ˆP) out of two reviewed for missing belongings.Findings include: On 06/29/2026 at 9:32 AM, an interview with the resident in room [ROOM NUMBER]ˆW revealed the resident had informed staff on several occasions that personal belongings were missing. The missing items included clothing, tennis shoes, and a blanket. The resident reported staff had labeled the items with the resident's name using a black marker. The resident said the missing items were neither returned nor replaced. On 06/29/2026 at 9:40 AM, an interview with the resident in room [ROOM NUMBER]ˆP revealed the resident had reported missing personal items to several facility staff members and had not received any resolution regarding the missing items. A review of the grievance log revealed six grievances filed between 12/11/2025 and 05/01/2026 in which residents reported missing personal items. The grievances documented that the residents' items were neither returned nor replaced. On 06/30/2026 at 1:30 PM, an observation of the laundry room revealed several collections of clothing, shoes, and blankets labeled no names. These items were observed in a laundry cart, on a table against the wall adjacent to the dryers, and on a shelf perpendicular to the aforementioned table. Staff A verified the items did not have name labels and said staff were unsure which residents the items belonged to. On 06/30/2026 at 1:22 PM, an interview with the Social Services Director (SSD) revealed most grievances filed with the facility were related to missing items. The SSD said an increase in laundry staff could help reduce the number of missing items. On 06/30/2026 at 1:30 PM, an interview with Staff A, Laundry Assistant, revealed Staff A does not deliver clothes to residents because, as the only laundry staff during the shift, resident linens and towels are the priority. Staff A also said the laundry area had recently received an influx of clothing items without name labels. Staff A said clothing without names usually accumulates in the laundry room and another staff member attempts to return the items to residents; however, the piles of unnamed clothing continue to increase. On 06/30/2026 at 1:40 PM, an interview with the Nursing Home Administrator (NHA) revealed clothing items without name labels are donated to a charitable organization about once per month. The NHA said that at other times, clothing items without name labels are given to residents who have fewer personal belongings. The NHA also said some items in the laundry room are occasionally delivered to the activities room so residents can attempt to identify their missing items. Upon request, a policy related to missing personal items was not provided by survey exit.

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure sufficient nursing staff to provide adequate supervision and prevent accidents. On 06/28/2026 during the 11 PM-7 AM shift, the facility assigned only one Certified Nursing Assistant (CNA) to the East Unit and one CNA to the Reflections Unit, affecting three residents (Residents #30, #117-P, and #111-P) out of three residents interviewed regarding staffing concerns. Residents reported delays in care and needing to rely on other residents for assistance due to inadequate staffing. Findings include:A review of the facility's Daily Assignment Sheet dated 06/28/2026 for the East Unit revealed one CNA was assigned to Rooms 100-128 for the 11 PM-7 AM shift. A review of the Daily Assignment Sheet for the Reflections Unit revealed one CNA was assigned to Rooms 200-210 for the same shift. A review of the Daily Assignment Sheet for the [NAME] Unit revealed two CNAs were assigned: one CNA was assigned to one resident in room [ROOM NUMBER] and the other CNA was assigned to Rooms 213-229. A review of the facility's Daily Staffing Form for 06/28/2026 showed the census was 85 residents. On 06/29/2026 at 9:40 AM, interviews with Resident #30, the resident in room [ROOM NUMBER]ˆP, and the resident in room [ROOM NUMBER]ˆP revealed that during the 11 PM-7 AM shift on 06/28/2026, there was only one CNA assigned to the unit where they resided. The resident in room [ROOM NUMBER]ˆP reported concerns related to residents calling out for help without receiving a response. All three residents stated that on 06/28/2026, residents asked other residents for assistance due to the lack of staff and to avoid burdening the single CNA. All three residents also reported there were occasions when they needed assistance but chose not to request help because the facility was understaffed. On 06/29/2026 at 3:21 PM, an interview with the Staffing Coordinator revealed the role includes ensuring the facility is staffed according to the census. The Staffing Coordinator confirmed that during the 11 PM-7 AM shift on 06/28/2026, one CNA was assigned to the Reflections Unit and one CNA was assigned to the East Unit. The Staffing Coordinator said several attempts were made to staff the shift, but staff declined to work. The Staffing Coordinator stated one CNA was assigned to Rooms 100-128 in the East Wing and said this assignment was not safe due to the number of residents but clarified this was their personal opinion. The Staffing Coordinator also said the facility did not have enough nurses on the roster to assign them to work as CNAs. At the time of the interview, the Staffing Coordinator had not spoken to residents to determine whether there were lapses in care during the 11 PM-7 AM shift on 06/28/2026. On 06/29/2026 at 6:32 PM, an interview with the Director of Nursing (DON) revealed that during the 11 PM-7 AM shift on 06/28/2026, one CNA was assigned to a 1:1 assignment in the [NAME] Wing, one CNA was assigned to the remainder of the [NAME] Wing, one CNA was assigned to the East Wing, and one CNA was assigned to the Reflections Unit. The DON stated the Nursing Home Administrator (NHA) was notified of the staffing shortage because approval was required to offer bonuses to staff who might agree to work the shift. The DON stated the facility does not use agency staffing.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain resident rooms in a safe, functional, and comfortable condition by not ensuring airˆconditioning (A/C) units were operational, adequately sealed, and free of environmental contaminants, and free from bio growth, in two units (100 and 200) out of three units observed. This resulted in room temperatures exceeding 81 degrees Fahrenheit and unsealed wall openings exposing residents to outside elements. Findings include: On 6/29/26 at 3:24 p.m., an interview was conducted with Resident #2. Upon entry into the room, a noticeable increase in temperature was observed. Resident #2 stated the air conditioner had been broken since before they moved into the room. Resident #2 stated the facility was aware of the nonˆfunctional A/C and provided a fan until repairs could be completed. Resident #2 stated they had lived in the room for at least three weeks without A/C, and their family member brought an additional fan due to the heat. Resident #2 stated the facility told them the unit required a replacement part, which they were informed about approximately two weeks prior. Resident #2 said they had been miserable due to the heat and were always sweating. By the end of the interview the room temperature measured 87.8 degrees Fahrenheit (F). A review of Resident #2's admission record revealed an admission date of 3/4/26 with diagnoses including paraplegia, polyneuropathy, chronic pain, and a traumatic brain injury (TBI). A review of Resident #2's Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. On 6/29/26 at 4:00 p.m., an interview was conducted with Staff B, CNA. Staff B stated Resident #2 had been without A/C since moving into the room and stated multiple rooms in the locked unit were experiencing similar issues with nonˆfunctional A/C units. On 6/29/26 at 4:20 p.m., an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated they were aware Resident #2's room did not have air conditioning and stated it was the resident's choice to stay in the room. The NHA stated the facility had been waiting a couple of weeks for a replacement part. On 6/29/26 at 4:45 p.m., Staff C, CNA, walked through multiple rooms in the locked unit where A/C units were not functioning or cooling properly. Staff C stated Rooms 201, 206, 207, and 209 had not had working A/C for ?a while now. On 06/29/26 between 4:45 p.m. and 6:30 p.m., observations in the 200 hall revealed nonˆfunctional A/C units in 10 resident rooms, including rooms [ROOM NUMBER], with temperatures above 81 F:room [ROOM NUMBER]: 82.2 [NAME] 206: 82.4 [NAME] 207: 83.4 [NAME] 216: 81.3 [NAME] 221: 81.3 [NAME] 222: 83.1 [NAME] 224: 83.1 [NAME] 225: 84.3 [NAME] 229: 83.1 F On 06/29/26 at 5:15 p.m., interviews with the NHA and DON revealed they were aware of A/C issues in only two rooms, rooms [ROOM NUMBERS], and stated replacement units had been ordered. On 06/29/26 at 5:25 p.m., the Social Services Director (SSD) stated no grievances had been submitted by Resident #2 regarding A/C concerns and confirmed the A/C unit remained nonfunctional. On 06/29/26 at 5:32 p.m., the A/C unit in room [ROOM NUMBER] was observed with visible biological growth inside the unit. The resident in Bed B of room [ROOM NUMBER] had documented respiratory concerns. A large circular black area of biological growth was observed on the ceiling tile above the sink. On 6/29/26 at 5:36 p.m., an interview was conducted with the Director of Maintenance (DOM). The DOM stated they had previously conducted temperature checks but had not documented them, despite having binders designated for recording facility issues. The DOM stated they were aware of only two rooms without working A/C. The DOM stated that if a room exceeded 81 F, a plan needed to be made for the resident, which could include changing rooms or exchanging units with an empty room. On 06/29/26 at 5:45 p.m., Staff C, CNA, stated the resident rooms ?are always hot' and stated administration had known ?for months' that several units were not working. Staff C stated the issue had been reported multiple times. During an interview on 06/29/26 at 6:14 p.m., the DOM stated he was new to the building and had been ?trying to patch things up.' The (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DOM stated the replacement A/C units were smaller than the original units, resulting in unsealed openings around the units that exposed residents to outside elements. The DOM stated he intended to purchase plywood to close the openings and was working with the NHA to obtain approval for complete replacement of the A/C units. On 6/30/26 at 9:51 a.m., an observation and interview were conducted with the NHA and Regional [NAME] President of Operations (RVPO) in room [ROOM NUMBER]. The NHA and RVPO were unable to identify the biological growth in the resident's A/C unit and on the ceiling tile above the sink and acknowledged the conditions were unacceptable and required immediate attention. A review of the facility's maintenance log showed no entries documenting malfunctioning A/C units in any rooms in the 200 hall. A review of the facility's Preventative Maintenance Checklist revealed that room inspections required checking A/C units, thermostats, and filters for proper operation. No completed room inspection checklists were available for the facility. A review of the facility's DOM Job Description revealed the following: The primary purpose of your job position is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current federal, state and local standards, guidelines, and regulations governing the facility to ensure it is maintained in a safe and comfortable manner. The DOM is responsible for the upkeep of the facility, including the building, building systems and grounds. Develop and ensure implementations of a preventative maintenance plan, which describes specific tasks, to be completed and the time frame for completion. Establish a equipment and utilities maintenance program. Participate in regular safety inspection tours of the facility and ensure documentation of findings. Determine and ensure implementation of corrective action needed as a result of internal or external safety inspections. A review of the facility's Safety Plan-Elevated Temperatures- Heat revealed the following:Dedicated staff member to pass ice/water/cool cloths throughout the day/night.Offer popsicles, ice cream, etc.Nursing: Take vitals to include temperatures every 4 hoursSend any residents who have signs and symptoms of overheating to the hospitalRecord ambient temperatures in various areas of the building and resident rooms. Be sure to keep a record. If a residents room are above 81 degrees, move to a cool zone or cooler area of the facility.