STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105708	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpark Health and Rehabilitation Center	2851 Tampa Rd Palm Harbor, FL 34684

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility did not ensure one resident (#1) out of three residents reviewed received appropriate treatment and services for mental disorders to attain the highest practicable mental and psychosocial well-being.Findings included: Review of Resident #1's hospital medication discharge instructions, dated [DATE], showed the resident received Nuplazid 34 mg daily. Review of Resident #1's facility physician orders showed:-Nuplazid Oral Capsule 34 MG (Pimavanserin Tartrate). Give 1 capsule by mouth one time a day for delusions. Dated 11/30/25. Review of Resident #1's Medication Administration Record (MAR) for December 1st-19th 2025 showed Nuplazid was not administered and was documented as waiting on delivery from pharmacy on 12/6, 12/7, 12/10, 12/11, 12/12, 12/13, 12/14, and 12/17/25. Nuplazid was signed off as being administered on 12/1, 12/2, 12/3, 12/4 12/5, 12/8, 12/9, 12/15, 12/16, 12/18, 12/19/25. Behavior monitoring on the MAR showed the only documented behaviors from 12/1-12/16/25 were three instances of insomnia and 1 instance of wandering. On 12/17, 12/18, and 12/19/25 the resident was documented to have aggressiveness and avoidance/resisting care. Review of admission Records showed Resident #1 was admitted on [DATE] with diagnoses including Parkinson's disease, major depressive disorder, anxiety disorder, dementia, and amnestic disorder due to known physiological condition. Review of Resident #1's Care plan showed a focus area of resident has an alteration in/risk for alteration in neurological status related to Parkinson's, dementia, dated 12/1/25. Interventions included Give medication as ordered. There was an additional focus area of resident has a mood problem, dated 12/1/25. Interventions included administered medication as ordered, behavioral health consults as ordered/indicated, and monitor/record/report to doctor as needed significant changes in signs and symptoms of depression, anxiety, sad mood, as indicated. Review of Resident #1's progress notes showed:12/17/25 11:31 a.m. Patient with agitation, hitting and kicking staff. Nuplazid cannot be delivered due to high cost, Psych services aware awaiting new orders.12/17/25 1:23 p.m. [Family member] was called to supply Nuplazid, no answer message was left for call back. Review of Resident #1's medical record did not show any documentation the resident was seen by psychiatry while in the facility. There was no documentation of a follow-up with psych related to the progress note on 12/17/25. An interview was conducted on 1/12/26 at 2:10 p.m. with a representative from the facility's pharmacy. The representative reviewed all medications ordered and delivered to the facility for Resident #1. The representative said a three-day supply of Nuplazid was delivered on 11/29/25 and that was the only time the medication was delivered to the facility for Resident #1. The representative said there were two notes in their system on 11/20/25 and 12/11/25 saying the Director of Nursing (DON) called and said not to send the Nuplazid. An interview was conducted on 1/12/26 at 1:48 p.m. with the DON. The DON reviewed Resident #1's medical record and confirmed the resident did not receive the ordered Nuplazid for several days in December 2025. She said the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expectation was that the facility get the ordered medication from the pharmacy and administer it to the resident. She said the family would not have been required to bring the medication to the facility. The DON confirmed there was no documentation psychiatry saw Resident #1 during his stay at the facility. When asked if Resident #1 should have been seen by psychiatry since he was not being administered his ordered medications for delusions; the DON stated she saw the documented behaviors, but he wasn't taken off the medication, he was taking it intermittently. An interview was conducted on 1/12/26 at 2:30 p.m. with the Nursing Home Administrator (NHA). The NHA said they checked with psychiatry and confirmed the Resident #1 was not seen in the facility. She said psychiatry attempted to see him on 12/11/25 but he was sleeping. The NHA said if a resident needed to see psychiatry other than their regular visit time, she said there is no reason that couldn't have happened. She said they did psychiatry telehealth visits when needed. The NHA said her expectation was that the facility obtained and administered the ordered medications, even high-cost medications.The NHA said the facility did not have a policy related to psychiatry services or mental health care. Review of a facility policy titled Physician Orders, reviewed 1/2024, showed:Guideline: Orders and administration of medications and treatments will be consistent with principles of safe and effective order writing.Procedure:1. Medications shall be administered upon the written order of a person duly licensed and authorized to prescribe such medications in this state as soon as practicable.9. Physician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated.10. The resident will be informed of medication changes as they occur. If the resident is deemed incapable of making health care decisions, the resident's responsible party will be informed of medication changes as they occur.