

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105708	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Oakpark Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to provide a sufficient number of certified nurse assistants (CNAs) for four night shifts (4/6, 4/12, 4/26, and 6/21) of the twenty-seven night shifts reviewed. Findings:An interview was conducted with Resident #93 on 12/08/2025 at 11:18 a.m. The resident stated they must wait awhile for assistance to get a brief changed. The resident stated the staff do not bring water unless the residents ask for water. The resident stated they asked to have water a week ago at approximately 9:00 pm and it took until 2:00 a.m. to receive it. An interview was conducted with Staff B, Registered Nurse (RN) on 12/09/2025 at 4:25 p.m. She stated each unit usually has six Certified Nursing Assistants (CNAs) and two nurses. She said if somebody calls out for their shift, Then we try our best. She stated the Director of Nursing (DON), and nurses on the units communicate staffing needs to the Staffing Coordinator based on census. Staff B stated she is a unit manager, and she fills in if there are not enough nurses.An interview was conducted with Staff Q, CNA on 12/09/2025 at 5:00 p.m. He stated he is usually assigned 10-12 residents for the 3 pm to 11 pm shift. He stated there are usually six CNAs on each unit at night. He said the Staffing Coordinator creates the schedules. He stated he is always busy, but he helps people. He stated he remembers one day with a CNA shortage, and he has worked there for one year.An interview was conducted with Staff W, CNA on 12/10/2025 at 8:23 a.m. She stated she is the Staffing Coordinator, and she also works as a CNA when needed. She confirmed the schedule is based on the census. She said she has a cheat sheet she uses to ensure requirements for staffing. She stated the facility is well covered with CNAs, and they are focused on hiring nurses. She said the facility is currently using agency nursing staff to meet the requirements. She stated they just started using the agency again a few days ago, but they prefer to use their own staff first. Staff W stated they have six CNAs on each unit, and never less than five CNAs on a unit. She said they know the residents' needs ahead of time, because most of the residents have been in the facility for a while. Staff W noted the facility tries to have an RN on every shift.Review of the Daily Schedule Reports for April 2025 through June 2025, with a comparison to the Raw Punch Reports, revealed the following data: -The facility staffing plan consists of 15-18 CNAs and 6 LPNs or RNs for the facility per shift.-The minimum regulatory requirement for staffing is a ratio of 40 residents to every licensed nurse, and 20 residents to every licensed CNA. -The night shift on the 4/6/2025, 4/12/2025, 4/26/2025, and 6/21/2025 did not meet this minimum staffing requirement. On 4/6/2025, the staffing numbers for the 174 resident census were seven CNAs and six licensed nurses. On 4/12/2025, the staffing numbers for the 175 resident census were seven CNAs and six licensed nurses. On 4/26/2025, the staffing numbers for the 173 resident census were seven CNAs and five licensed nurses. On 6/21/2025, the staffing numbers for the 171 resident census were seven CNAs and six licensed nurses.		

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure skin checks were completed for three Residents (# 6, #14, #35) out of eight residents sampled for skin integrity. Findings included: 1. On 12/09/2025 11:30 a.m. and at 3:00 p.m. Resident # 14 was observed lying down in bed with her call light within reach. She was observed groomed with no odors and no signs of distress. Review of an admission Record dated 12/11/2025 revealed Resident # 14 was admitted to the facility on [DATE] with diagnoses to include but not limited to Parkinson's disease without dyskinesia, without mention of fluctuations, bipolar disorder, current episode mixed, moderate, major depressive disorder, recurrent, moderate. Review of Resident # 14's order summary revealed: Weekly skin checks every Friday for skin assessment. Dated 10/10/2025 Review of Resident # 14's Treatment Administration Record (TARs) revealed: October 2025 Weekly skin checks were not documented as 1 out of 4 scheduled times completed December 2025 Weekly skin checks were not documented as completed On 12/10/2025 at 12:12 P.M an interview was conducted with Staff BB, RN. Staff BB stated she is not a full-time nurse at the facility so she can't explain why Resident # 14's skin checks were not completed as physician ordered. On 12/10/2025 at 12:30 P.M., an interview was conducted with Staff Y, License Practical Nurse/ Unit Manager. Staff Y stated her skin checks should be completed as ordered. If a nurse could not administer treatment, then they should document in the medical record the reason and notify the resident provider. 2. On 12/08/2025 at 10:42 a.m., Resident #35 was observed sitting in bed with the call light in his hand. A slight urine odor observed. A clean brief was observed on the chair next to resident. Observed a bandage on right side of his forehead, dated 12/6. The resident had sores on the forehead above the eyebrows. Review of admission Records showed Resident #35 was admitted to the facility on [DATE] with diagnoses including but not limited to parkinson's disease without dyskinesia without mention of fluctuations , adult failure to thrive, Weakness, Unspecified protein-calorie malnutrition, unspecified (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dementia, unspecified severity, without behavioral disturbance , psychotic disturbance, mood disturbance and anxiety. Review of Resident #35's Minimum Data Set (MDS), dated [DATE], showed a Brief Interview for Mental Status (BIMS) score of three indicating impaired cognition. Review of Skin Conditions, showed one stage II pressure ulcer and one stage III pressure ulcer. Review of the wound evaluations for Resident# 35's Stage III pressure ulcer on the sacrum revealed the following measurements: On 11/12/2025, the ulcer measured 3.0 cm in length, 1.7 cm in width, and 0.2 cm in depth. On 11/19/2025, the ulcer measured 1.9 cm in length, 1.7 cm in width, and 0.1 cm in depth. On 12/10/2025, the ulcer measured 7.1 cm in length, 2.1 cm in width, and 0.1 cm in depth. An interview was conducted with Staff G, CNA on 12/10/2025 at 10:54 a.m. She stated the CNAs usually do rounds every two hours. She said the care provided depends on the resident, and some may have to be checked every hour. She explained that if residents have pressure ulcers, then it is important they check often to make sure the residents are dry. Staff G said she would notify the nurse if sores were not healing or worsening An interview was conducted with Staff T, CNA on 12/10/2025 at 8:45 a.m. She said she would notify the nurse if there were a skin condition. The residents are rotated every 2 hours. She stated if residents refuse care, then she would tell the nurse. The policy is not to touch the resident if they refuse care. We let the nurse know. An interview was conducted with the Assistant Director of Nursing (ADON) on 12/10/2025 at 11:04 a.m. The ADON stated she is also a wound care nurse. She stated the wound care nurses round weekly for pressure injuries, with a Physician's Assistant (PA) from a wound care consultant. She said the PA will give recommendations if there is no progress, then she will make changes to care. She stated the facility has a wound care nurse daily. The ADON treats wounds during the week and Staff U, RN completes wound care on weekends. The ADON noted that bandage changes depend on the wound type. She said skin tears are better covered and bandages are changed three times a week. The ADON said pressure sore bandages are changed every day. She noted that Resident #35's facial wound and pressure sores were present on admission. She stated it was due to be changed today, 12/10/25. The order for the wound dressing change is three times a week. It falls on Monday, Wednesdays, and Saturdays. She thinks training for wound care is completed at least annually. She said she is not sure when the last training was completed. An interview was conducted with Staff U, RN, a wound care nurse on 12/10/2025 at 3:20 pm. Resident #35's bandages are changed every Monday, Wednesday, and Saturdays or as needed. She confirmed that on Monday, 12/8/25, the bandage on the resident's face was not changed. She confirmed the nurses can change bandages as well if the wound care nurse is not available. Review of Resident #35's November and December 2025 Medical Administration Record (MAR)/Treatment Administration Record (TAR) revealed the following wound care orders: Order: Treatment as follows; clean sacrum with normal saline, apply calcium alginate and cover with (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	super absorbent dressing (SAD) every day shift. Order start date was 11/10/2025 at 6:45 a.m. and discontinue date was 12/07/2025 at 4:52 p.m. The following dates had no treatment administration documented: 11/17/2025, 11/26/2025. Order: Treatment as follows; clean right second toe with normal saline, apply calcium alginate, absorbent dressing (ABD) and wrap with kerlix every evening shift on Monday, Wednesday, Friday, and Sunday for wound care. Start date was 11/09/2025 at 2:45 p.m. and discontinue date was 11/19/2025 at 9:07 a.m. The following date and times had no treatment administration documented: 11/9/2025 Order: Apply skin prep to bilateral heels as tolerated every shift as tolerated for 14 days. The start date was 11/08/2025 at 10:45 p.m. The evening shift on 11/9/2025 had no treatment administration documented. Order: Encourage and assist resident with turning and repositioning when in bed as tolerated every shift. The start date was 11/08/2025 at 10:45 p.m. The following evening shifts on 11/9/2025, 11/26/2025, 12/2/2025 and day shift on 12/9/2025 had no treatment administration documented. Order: Monitor the scab on the right side of the forehead, notify the doctor for any drainage or signs and symptoms of infection every shift. The start date was 11/09/25 at 2:45 p.m. and discontinue date was 11/15/2025 at 11:31 am. The following shift had no treatment administration documented: Evening shift on Sunday 11/9/2025 and Day shift on Saturday 11/15/2025. Order: Treatment as follows: clean lower back with normal saline, apply xeroform and cover with super absorbent dressing every day shift every Monday, Wednesday, Friday and Sunday. The start date 12/08/2025 at 6:45 a.m. No treatment was documented for 12/08/2025. Order: Clean open scab for right temporal area with normal saline, apply calcium alginate and cover with dry dressing. Change 3 times a week, every Monday, Wednesday, and Saturday. The start date was 11/22/2025 at 6:45 a.m. No treatment was documented for day shift on 12/08/2025. Order: Clean left ankle with normal saline, apply calcium alginate, ABD, and wrap with kerfix every day shift Monday, Wednesday, Friday and Sunday. The start date was 12/08/2025 at 6:45 a.m. No treatment was documented for day shift on 12/08/2025. Order: Treatment as follows; clean sacrum with normal saline, apply honey hydrogel, and cover with super absorbent dressing every day shift. Start date 12/08/2025 at 6:45 a.m. and discontinue date of 12/10/2025 at 7:56 p.m. No treatment was documented for day shift on 12/08/2025. 3. An interview was conducted on 12/9/25 at 11:29 a.m. with Resident #6. The resident said his tailbone hurt and that he previously had a wound there. He said it had been hurting for a little while, but the nurses did not do his skin checks. He said only the CNAs saw his buttock area when they changed him. Review of admission Records showed Resident #6 was admitted on [DATE] with diagnoses including quadriplegia and scoliosis. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #6's physician orders showed: -Weekly skin check. Every evening shift every Thursday. Dated 5/1/25. -Apply skin prep to left outer ankle every shift. Dated 4/17/25. -Apply skin prep to right outer ankle every shift. Dated 4/17/25. Review of Resident #6's Treatment Administration Records (TARs) showed: September 2025 Weekly skin checks were not documented as completed 4 out of 4 scheduled times. Skin prep was not applied to the left and right outer ankle 22 out of 90 scheduled times. October 2025 Weekly skin checks were not documented as completed 3 out of 5 scheduled times. Skin prep was not applied to the left and right outer ankle 9 out of 90 scheduled times. November 2025 Weekly skin checks were not documented as completed 2 out of 4 scheduled times. Skin prep was not applied to the left and right outer ankle 10 out of 90 scheduled times. December 2025 Skin prep was not applied to the left and right outer 4 out of 23 scheduled times. An interview was conducted on 12/11/25 at 1:35 p.m. with Staff O, RN/Wound Care Nurse. Staff O said she was unaware skin checks were not being completed as ordered. She reviewed Resident #6's medical record and confirmed the skin checks were not completed as ordered. Staff O said those items should trigger a red notification on the charting system dashboard and Unit Managers (UM) should review those at the end of each shift to ensure they are completed. Staff O said she did audits previously but was then told by the Director of Nursing (DON) that the UM should be the ones auditing to ensure orders were completed. Staff O agreed it was a concern that orders were not completed. An interview was conducted on 12/11/25 at 2:53 p.m. with the DON. The DON said skin checks and treatment should be completed as ordered. She reviewed Resident #6's medical record and confirmed there was no documentation that the skin checks were completed as ordered. The DON said skin checks should be audited by Staff O, RN/Wound care nurse. The DON said she used to do audits at least. The DON said UM should also be doing audits to ensure orders are being completed and signed off in the medical record. The DON agreed it was a concern that skin checks and treatments were not completed as ordered and said she had not been aware it was a concern. Review of a facility policy titled Prevention of Skin Impairments/Pressure Injury, revised 1/2024 (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed: Standard: The purpose of this policy is to provide information regarding identification of skin wound risk factors and interventions for specific risk factors. Guideline: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk Factors: 1. Not all risk factors are fully modifiable or can be completely addressed. 2. Examples of these risk factors include, but are not limited to: a. Impaired/decreased mobility and decreased functional ability; b. Co-morbid conditions, such as end stage renal disease, thyroid disease or diabetes mellitus; c. Drugs such as steroids that may affect healing; d. Impaired diffuse or localized blood flow, for example, generalized atherosclerosis or lower extremity arterial insufficiency; e, Resident refusal of some aspects of care and treatment; f. Cognitive impairment; g. Exposure of skin to urinary and fecal incontinence; h. Under nutrition, malnutrition, and, hydration deficits; and The presence of a previously healed PU/PI. The history of any healed PU/PI, its origin, treatment, its stages [if known] is important assessment information since areas of healed Stage 3 or 4 PU/PIs are more likely to have recurrent breakdown. Prevention: 1. Select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors. 2. Based upon the assessment and the resident's clinical condition, choices and identified needs, basic or routine care could include, but is not limited to, interventions to: a. Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.); b. Minimize exposure to moisture and keep skin clean, especially of fecal contamination; c. Provide appropriate, pressure-redistributing, support surfaces; d. Provide non-irritating surfaces; and (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. Maintain or improve nutrition and hydration status, where feasible. Adverse drug reactions related to the resident's drug regimen may worsen risk factors for development of, or for non-healing PU/PIs (for example, by causing lethargy or anorexia or creating/increasing confusion) and should be identified and addressed. These interventions should be incorporated into the plan of care and revised as the condition of the resident indicates. Monitoring/Documenting 1. Evaluate, report, and document potential changes in the skin. 2. Notify the physician and the resident/resident representative of changes in the skin. 3. Review the interventions and strategies for effectiveness on an ongoing basis. 4. Evaluate open areas (pressure/surgical areas) per physician orders.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 reviews, the facility failed to ensure post fall interventions were implemented to prevent future falls for four residents (#20, #78, #138, #149) out of seven residents sampled for falls. Findings included: 1) Review of a facility provided incident log showed Resident #138 had falls on 11/26/25 and 12/8/25. Review of admission Records showed Resident #138 was admitted on [DATE] with diagnoses including essential sarcopenia, other symptoms and signs involving the musculoskeletal system, paroxysmal atrial fibrillation and syncope and collapse. Review of Resident #138's progress notes showed: 11/26/25 3:25 p.m. Alerted by CNA [certified nursing assistant] that Pt [patient] was on the floor. Pt observed laying flat on his back, on side of bed by window. Noted skin tear to left shoulder blade, pt c/o [complaints of] left side/hip pain. Pt states he did hit head but is not hurting, no redness or deformities noted. Pt was assisted into bed. Pt declining PRN [as needed] pain medcations [sic]. Pt noted with labored [sic] breathing O2 85% on RA [room air], Pt placed on 2 L [liter] O2 and [NAME] TX given , O2 93%. MD, Family and DON aware 11/26/25 3:10 p.m. Fall Evaluation The following interventions and approaches have been implemented for the residents: Review footwear needs Call light re-orientation Review of Resident #138's Care Plan showed a focus area of being at risk for falls related to cognitive deficit, history of falls, unaware of safety needs, unsteady gait/poor balance, use of antihypertensives, and antidepressant medication. Review of the interventions did not show any interventions were added after the resident fell on [DATE]. The interventions for footwear needs and call light re-orientation were added as interventions in the care plan prior to the fall on 11/26/25. An interview was conducted on 12/11/25 at 2:53 p.m. with the Director of Nursing (DON). The DON reviewed Resident #138's medical record and confirmed no new fall interventions were added after the resident fell on [DATE]. The DON said interventions should have been added after that fall in an attempt to prevent future falls. Review of Resident #138's progress notes showed: 12/8/25 3:52 p.m. Notified by CNA that Pt. was on the floor. I observed Pt sitting on the floor by bathroom and wheelchair. Body audit complete, no injuries noted or reported. Pt states he was opening bathroom door and slid out of wheelchair. Pt denies hitting head, Pt denies any pain. VS wnl [within normal limits]. Pt assisted into wheelchair. Pt self propelled to dining room for Lunch. MD [medical doctor] (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and family notified. 2) On 12/09/2025 at 3:00 pm an observation was made revealing Resident # 20 sitting in her wheelchair propelling up and down the hallway. She was observed with no signs of distress On 12/11/2025 at 10:00 am an observation was made revealing Resident # 20 sitting up in her wheelchair, with no signs of distress. Review of Resident # 20 admission record revealed she was admitted to the facility on [DATE] with diagnoses to include but not limited to permanent atrial fibrillation, age-related osteoporosis without current pathological fracture, cognitive communication deficit. Review of Resident # 20's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 07 which indicated Resident 20 is severely cognitive impaired. Review of a progress note dated 4/3/2025 revealed Resident # 20 was found on the floor. The progress note revealed an assessment was completed noting Resident # 20 had a Quarter sized bump on the left side of her head. Review of Resident # 20's fall care plan initiated on 12/24/2025 revealed no new interventions added after Resident # 20 fall on 4/3/2025. Review of Resident # 20's Medical Record reviewed on 12/ 11/2025 revealed no evidence of a quality of care note with the doctor's response to show Resident # 20 did not need a new intervention added after her fall on 4/3/2025. On 12/11/2025 at 3:00 pm., an interview was conducted with the Director of Nurses, DON. The DON stated that after every fall there is a new intervention put in place and added to the resident care plan. The only time they will not add a new intervention is if the doctor provides them with information that all interventions for the resident after a fall have been put in place. If the doctor provides them with that response, there would be documentation such as a quality of care note with the doctor's response. 3) An interview was conducted with Resident #143 on 12/08/2025 at 9:56 a.m. who stated Resident #78, had a bad fall recently. Resident #78 fell while using their walker because the wheels slipped out from under them. Resident #143 stated the doctor evaluated Resident #78 and decided to keep them in the facility. Review of admission Records showed Resident #78 was admitted to the facility on [DATE] with a diagnosis including but not limited to chronic kidney disease, stage three, unspecified. The resident has a diagnosis of unspecified dementia, unspecified severity without behavioral disturbance. The onset of dementia was documented as 8/15/2023. Review of Resident #78's Minimum Data Set (MDS), dated /15/2, Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of three. This BIMS score indicating the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's cognition was moderately impaired. On 12/09/2025 at 4:50 p.m., Resident #78 was observed walking down the hall with a walker. The resident was walking quickly and appeared to have a steady gait. The resident was observed walking through the halls during the day. On 12/09/2025 at 5:10 p.m. Resident #78 was observed in their room standing next to the bed. A large bruise was observed on the right side of their forehead. Review of nursing progress notes dated 11/15/2025 at 4:08 p.m. revealed the resident had a large knot on her right forehead due to her fall. Review of the resident's care plan, with an initiated date of 08/26/2025, showed the care plan was not updated to address the fall by adding interventions to reduce future risk. An interview was conducted with the DON on 12/11/2025 at 6:33 p.m. The DON stated Resident #78 walks through the halls frequently throughout the day. She said the care plan should be updated after any resident falls. The DON confirmed the care plan was not updated for Resident #78. She revealed the plan was supposed to be updated with more rest periods for the resident. 4) Review of admission records showed Resident #149 was originally admitted on [DATE] and admission on [DATE], with diagnoses including metabolic encephalopathy, chronic obstructive pulmonary disease (COPD), neuropathies, bipolar disorder, chronic pain, history of falling and major depressive disorder. Review of Resident #149's care plan Focus: the resident is at risk for falls related to (R/T) weakness, medication use, initiated on 6/9/25. Goal: the resident potential for sustaining a fall related injury will be minimized by utilizing fall precautions/ interventions through the next review date. Interventions: assist to toilet before and after meals- 12/10/25, offer toilet upon rising- 6/27/25, perimeter mattress- 11/6/25, encourage and assist resident to use bed in the lowest position as tolerated-6/9/25, encourage and remind resident to use call bell and wait for staff assistance with transfers, ambulation, toileting, etc., as indicated-6/9/25, encourage to transfer and change positions slowly-11/26/25, encourage and assist the resident to wear appropriate footwear such as rubber-soled shoes, non-skid bedroom slippers, non-skid socks., etc. when ambulating, transferring or mobilizing in wheelchair-. 6/9/25, physical and occupational therapy consult as needed- 6/9/25, educate/ discourage resident from unsafe activities, such as opening closed doors/ reaching in wheelchair; wait for staff to assist-9/15/25. Review of Resident #149's quarterly Minimum Data Set (MDS), dated [DATE] Section C, cognitive pattern showed a Brief Interview for Mental Status (BIMS) summary score 10, indicating moderate cognitive impairment. Section GG, functional abilities showed partial/ moderate assistance is needed for personal hygiene and sit to stand and substantial/ maximal assistance for chair to bed transfer. Resident #149's progress notes showed the following: A fall evaluation note, dated 11/24/25 at 11:40 PM, showed The following interventions and approaches have been implemented for the residents: Bed in lowest position Call light re-orientation . The fall risk evaluation was reviewed with the following people: Resident . Education was provided to (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Oakpark Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2851 Tampa Rd Palm Harbor, FL 34684	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following people: Resident . The teaching methods used for the education provided was: Verbal Discussion. The outcome of the education provided was Verbalizes Understanding. An eINTERACT SBAR Summary for Provider note dated 11/24/24 at 11:42 p.m. showed Resident #149 fell. A progress note dated 11/29/25 at 12:15 a.m., this writer heard patient (pt) yelling, entered room and pt laying on her back on floor in between bed and window. asked pt what happened pt Stated I rolled out of bed. pt was assessed for injury and range of motion (ROM) pt denies hitting head assist of 2 back to bed pt able to stand neuro checks initiated .call bell was not activated. A progress note dated 12/7/25 at 6:29 p.m. showed Pt observed on floor, beside bed facing window wall. Pt unable to state how she got on floor. Pt obtained skin alteration on left upper arm. Assisted pt off the floor x 3, neurological check (neurocheck) within normal limits (wnl), vital signs (v/s) wnl. Pt was provided first aid to left arm and was referred to wound care. Notified the power of attorney (POA) and the advanced registered nurse partitioner (ARNP) placed pt on neuro checks. During an interview on 12/11/2025 at 3:10 p.m. the Director of Nursing (DON) said on 11/24/25 Resident # 149 was observed lying on the floor on the left side. She stated that no interventions related to the fall on 11/24/25 were added to the resident's care plan. She explained that after each fall, the IDT meets during the morning meeting to review the incident and assign responsibility for updating the care plan, typically to the MDS Coordinator During an interview on 12/10/25 at 10:40 a.m., the DON stated following a resident fall, staff are required to complete a skin assessment and a pain assessment. If the fall is unwitnessed, neurological checks are also performed. The manager added that employee statements are obtained as part of the post-fall investigation, and resident-specific interventions are reviewed, discussed, and implemented to help prevent future falls. The DON said on 12/8/25, the clinical team met to discuss Resident #149's fall that occurred on 12/7/25. During the meeting, the team decided to add an intervention instructing staff to toilet the resident before getting into bed and after getting out of bed. The Director of Nursing (DON) stated the MDS Coordinator should have updated the care plan with the new interventions. Review of facility policy titled, Standards and Guidelines: Falls-Managing, Preventing and Documentation, revise 9/2005, showed the following: Guideline: Each resident will have an individualized plan of care that will be reviewed and modified as needed to included fall interventions most appropriate to their individual needs and diagnosis. Definition: Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, OR as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for staff intervention, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. If there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall. Procedure: Fall Risk Factors 1. Some factors that may result in resident falls include, but are not limited to (a) Environmental hazards, such as wet floors, poor lighting, etc. (b)Unsafe or absent footwear and loose or improperly worn clothing; (c) Underlying chronic medical conditions, such as (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	arthritis, heart failure, anemia and neurological disorders; (d)Acute change in condition such as fever, infection, delirium; (e)Medication side effects; (f) Orthostatic hypotension; (g) Lower extremity weakness; (h) Balance disorders; (i)Poor grip strength; (j) Functional impairments (difficulty rising from a chair, getting on or off toilet, etc.); (k) Gait disorders; (l) Cognitive impairment; (m) Visual deficits; (n)Pain; and (p) Refusals of with fall interventions, physician orders, plan of care, and/or staff assistance. Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e.to try one or a few at a time, rather than many at once). 3. Examples of initial approaches might include bed in lowest position, call light in reach, improving footwear, changing the lighting, etc. 4. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 5. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or until the reason for the continuation of the falling is identified as unavoidable. 6. Staff will identify and implement relevant interventions to try to minimize serious consequences of falling. 7. The facility is a restraint free environment. Meaning, bed alarms, chair alarms, side rails solely for fall prevention, and chemical interventions for fall prevention are not utilized. Monitoring Subsequent Falls and Fall Risk: 1.If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 2. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. Documentation: 1. Residents who experience a fall will have appropriate documentation completed in the facility risk management portal or on paper. 2. The residents care plan should be updated timely with the new interventions determined by the interdisciplinary team.		

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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 observations, interviews, and record review, the facility failed to provide sufficient staffing to meet the needs of the residents related to dining and Activities of Daily Living (ADL) assistance with meals for three residents (#134, #50, and #168) observed in the dining room during three days (12/8/2025, 12/9/2025, and 12/10/2025) of three days dining was observed. Findings included: On 12/8/2025 at 12:50 p.m. the main dining room was observed during the lunch meal service. The main dining room revealed two sections, one large for residents who eat without assistance, and a smaller section where residents are assisted with their meals from staff. The smaller assistive section was observed with eight residents seated at various tables and with only one staff member in the room, who was Certified Nursing Assistant (CNA) Staff M. Staff M was observed seated at a table assisting a resident with eating assistance, where Resident #134 was also seated. Staff M was observed to only assist the table mate of Resident #134 with her lunch meal. Resident #134 was observed during the entire meal pushing most of her food off the plate and onto the table, as well as on her lap, and also observed picking up food from her plate with her fingers. Resident #134 was not served a meal that was finger foods. Resident #134 also picked up her juice cup and spilled it all over her plate with food, as well as most of it all over the table. Staff M continued to assist Resident #134's tablemate and did not intervene with Resident #134, nor cue her to stop pushing food off her plate. There were no other staff in the assistive section to assist. It appeared most of the eight residents in this assistive dining room needed some form of staff assistance to include either full eating assistance or cueing. Two residents #50 and #160 were observed seated at tables with their plates in front of them and were not eating, nor were they attempting to eat on their own. It was noted both needed either cueing supervision or limited eating assistance from staff. There were no other staff in the room from a timeframe of thirty-five minutes beginning at least 12:50 p.m. through to 1:25 p.m. Staff M confirmed she was the only staff member in the smaller room during that period of time and there are usually other staff in the room to assist. It was noted another staff member, who was the Assistant Director of Nursing (ADON), was assisting passing trays in the larger section of the dining room, as well as transporting tray carts from dining room to hallways, and from hallways to dining room. Interviews were attempted with Residents #134, #50, and #168. However, none were able to answer questions about their eating assistance, as they had cognitive impairments preventing them to be interviewed. On 12/9/2025 at 12:01 p.m. the main dining room assistive section was observed for the lunch meal service. There were twelve residents seated at various tables to include Residents #134, #50 and #169, and with only two staff members Certified Nursing Assistants (CNAs) Staff P and Q. All residents were already served and set up with their meals with Staff P was seated next to Resident #50 and Staff Q was seated next to Resident #168. It was observed Staff P and Staff Q were only providing eating assistance to Residents #50 and #168. There were ten others in the room to include Resident #134, who was not being assisted with cueing and eating assistance. Resident #134 appeared to have to wait until someone arrived to get them started with eating. Resident #134 was observed seated at a table with two other residents. Resident #134 picked up a clear plastic cup filled with a pink liquid and attempted to bring it to her mouth. While bringing the cup to her mouth, she spilled a large amount of liquid on her plate of food and also the table. There was no staff in the immediate area to intervene and assist her. Resident #134 continued to attempt to drink the liquid and put the cup down and continued to grab at her food items. She put food items in her mouth and did not use eating utensils. She continued to pick up food items with her fingers and food dropped on her lap and on the table. Resident #134 was observed to do this several times before she reached over and picked up her table mate's cup of pink liquid. At that time Staff P had to stop assisting with feeding Resident #50, got up and walked over to Resident #134 to intervene. Staff P grabbed the cup and (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	placed it back to where Resident #134's table mate was at. She then went back to Resident #50 to finish assisting her with her meal. At 12:09 p.m. a staff member, who was a visiting Regional Dietary Manager, was observed to walk into the assistive dining section and sat down with Resident #134 to await further assistance from other staff. The Regional Dietary Manager is not an employee who regularly works at the facility, nor regularly sits to assist residents with their meals. At 12:10 p.m. Staff P finished assisting Resident #50 with her meal and then got up and walked over to Resident #134 to assist her with her meal. At 12:11 p.m. the ADON was observed to bring an empty tray cart into the room. After she did so, she immediately sat down next to Resident #134 after Staff P got up and began to assist her with eating. It was noted Resident #134 went from at least 12:01 p.m. through to 12:09 p.m. without any supervision, cueing and or eating assistance for eight minutes, resulting in spilled food and drink all over the table and plate of food. There were others in the room who needed assistance with eating and they too had to wait until Staff P and Q finished assisting Residents #50 and #168. Staff Q was observed to stop assisting Resident #168 with eating assistance three times and got up to either redirect other residents when spilling food/drink, or to assist with putting fork full of food to residents mouths. Staff Q would go back to Resident #168 each time after intervening with the other residents. At 12:33 p.m. an interview with Staff Q, who was now seated and assisting with eating with another resident at another table, revealed she does not normally help in the assistive dining room and was asked to do so today. She confirmed she and other staff had left Resident #134 without assistance for some time as she and others were passing and setting up meal trays for others. Staff P confirmed Resident #134 needs continued monitoring and assistance with her meal and confirmed she does grab at tablemate's food and utensils. At 12:36 p.m. an interview with Staff Q revealed he does not normally help with assisting residents with eating in the dining room. He mentioned it was his first time and was asked to come in the room to assist Resident #168 with his eating tasks. Staff Q confirmed there were others in the room who needs assistance with either cueing or full eating assistance. But he nor Staff P can assist with them all. Staff Q was not sure who else should be in the room to help. At 12:39 p.m. while in the 100 hallway, an interview was obtained with CNA Staff M. She confirmed she was assigned in the assistive dining room the day prior on 12/8/2025 and she was not assigned to help in that area today. She revealed she floats for assignments and there are times when she is in the dining room assisting and there are times when she assists in the hallways passing trays to residents while in their rooms. Staff M confirmed she was at a table in the assistive dining room the day before on 12/8/2025, and was assisting another resident at the same table where Resident #134 was at. Staff M confirmed she did not assist Resident #134 as she was assisting another resident at the table, and confirmed Resident #134 was spilling liquid in her food, and was pushing food off the plate to the table and her lap. Staff M again said she did not assist Resident #134 as she was not assigned to her at that time. Staff M confirmed Resident #134 needed constant supervision and eating assistance, but there was nobody else in the dining room at the time to assist. Staff M felt there should have been more help in the room to help all the residents who required eating assistance. On 12/10/2025 at 8:02 a.m. Resident #134 was noted in her room and lying flat in bed and under the covers. She was observed with her eyes closed and with the call light placed within her reach. The over the bed light was on only. The over the bed table was observed placed at bedside and with the breakfast meal tray placed on it. The lid was covering the plate. At 8:09 a.m. the floor nurse Staff N was at her medication cart just outside the resident's room and she confirmed the resident would be eating in her room and she does require total assistance with eating. Staff N was not sure who was assigned to her to assist with eating, but she did confirm that residents normally eat while in their rooms for breakfast. At 8:17 a.m. Resident #134 was still noted in her room and in bed with her breakfast meal tray placed on the over the bed table. Staff have yet to come in and assist her with eating. At 8:24 a.m. a Staff M was observed to go in the room and closed the door. At 8:30 a.m. the door was opened and Staff M was observed finishing with ADL care with Resident #134's room mate. She was observed to have changed clothes and bed linen for the room (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mate. Staff M revealed she will be assisting Resident #134 with her meal in a minute as she had to change the room mate's clothes and bed linen. Staff M confirmed the breakfast tray had been in the room for a little while but could not get to Resident #134 yet. It was found Resident #134 was not assisted with her breakfast meal until 8:36 a.m., which was thirty-two minutes after staff had originally placed the meal tray on the over the bed table. At 8:55 a.m. Staff M presented Resident #134's meal tray and it was found after she was assisted with her meal, she did consume 50% of her meal. Staff M confirmed Resident #134 needs assistance with eating and that most of the time she has to feed her, but she does try to cue the resident to pick up the utensil and eat on her own. Staff M confirmed Resident #134 will and does push food off her plate with her fingers and tries to pick up the food items with her fingers as well. It was found through three separate dining observations to include dates 12/8/2025, 12/9/2025 and 12/10/2025, Resident #134, #50, and #168 needed more than Supervision or Touching assistance with Eating Activity of Daily Living (ADL) tasks. It was also found there was not enough staff to provide ADL eating assistance in the (Assistive) dining room as there were residents who had to wait until staff finished with others. Residents in the (Assistive) dining room were not able to make their needs known and were not interviewable. On 12/11/2025 at 12:34 p.m. an interview with the 300 unit Medbridge nurse Staff R revealed she was knowledgeable of Resident #134 and revealed she requires eating assistance and cueing at times and has declined recently. Staff R revealed Resident #134 has Dementia and Alzheimer's and usually needs more than cueing. Staff R revealed she was not aware of lack of staff supervision and assistance for Resident #134 during meal services and explained the schedule of staff changes from day to day in the dining room. She confirmed when residents are in their room and requires assistance with eating, staff should not drop the tray off and leave and come back at a later time to assist. She confirmed the tray should be brought into the room at the same time the resident will be assisted. Staff R also revealed there should be a schedule for staff to assist residents while in the dining room. She revealed there are different staff on different days but does not know who was responsible for ensure those staff get to the dining room to assist. On 12/11/2025 at 12:40 p.m. an interview with the Assistant Director of Nursing (ADON) revealed she normally supervises and assists with meal service and tray pass for most meals, during the days she works. She revealed during the breakfast meal service, she oversees and assists with trays being passed to residents while in their rooms, as the dining room is not utilized during this meal service. She also revealed she assists with the lunch meal service and will receive and place meal carts from the kitchen to either hallways on Medbridge unit or in the main dining room. The ADON confirmed the main dining room has two sections with a smaller section for residents who require eating assistance or cueing with meals. The ADON revealed she normally supervises and assists in this assistive dining room section and will ensure those who need assistance, receives assistance. The ADON revealed there is a rotation of staff between the units with staff who assist with eating ADLs in the assistive dining room. She revealed one day there will be staff assigned and on another day there will be different staff assigned. She did not have a schedule for review. The ADON specified if a resident requires full eating assistance, a staff member must assist with only that resident. She revealed if a resident requires cueing, staff who are assisting residents, can cue other residents from where they are seated. The ADON revealed when staff are seated and assisting with eating for one particular resident, they are not to get up and leave the resident for any time to help others. The ADON revealed she was not aware that on 12/8/2025 and 12/9/2025 during the lunch meal service in the assistive dining room of staff getting up and leaving their assigned resident to help others, and was not aware Resident #134 was left with no one to assist her with eating assistance or cueing. She revealed she did have to assist and supervise meal tray pass in the hallway and in the main dining room (un assistive) section. The ADON confirmed there should have been more staff in the assistive dining room to assist 8-12 residents with eating. She confirmed there are usually more aides in the room to assist with these tasks. Review of Resident #134's medical record revealed she was admitted to the facility on [DATE]. Review of the advance (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	directives revealed Resident #134 had a responsible party to make her medical and financial decisions. Review of the admission diagnosis sheet revealed diagnoses to include but not limited to: DMII, Alzheimer's disease, Anemia, Dysphagia, Conversion disorder with seizures, Insomnia, Depression. Review of the most current Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE], revealed; (Cognition/Brief Interview Mental Status or BIMS score 00 of 15, which indicated Resident #134 was not interviewable and would not be able to speak related to her medical care and services); (Activities of Daily Living related to EATING = Supervision and touching assistance). On 12/11/2025 at 5:00 p.m. the Director of Nursing did not have a specific Staffing the dining room policy and procedure for review. The Director of Nursing instead provided the Quality of Care, Standards and Guidelines: ADL Care and Services policy with a last review date 1/2024, for review. The policy revealed;Standard: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).Guideline: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Procedure: 1. Residents will be provided with care, treatment, and services to e sure that their activities of daily living (ADLs) are met.4 . Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with, including but not limited to: Dining (meals, hydration, snacks).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure proper infection control practices were implemented related to: 1) personal protective equipment (PPE), contact precautions, hand hygiene, soiled linen, and resident bathrooms on two out of three resident units observed; and 2) failed to properly sanitize the heel protector boot for one resident (#2) out of thirty-three sampled residents. Findings Included: An observation was conducted on 12/8/25 at 9:56 a.m. of the 100 unit shower room. The shower room was observed to have dirty linens in a pile on the floor, hanging on the shower chair, and on the rails in the shower. A Certified Nursing Assistant (CNA) was observed wheeling a resident into the shower room to have a shower prior to it being cleaned. An observation was conducted of the 100 hall lunch service on 12/8/25 at 12:18 p.m. A staff member was observed removing a tray from the tray cart, taking it into a resident room and setting the tray up for the resident. The staff member then returned to the tray cart and retrieved a tray for another resident without performing hand hygiene. A second staff member was observed removing a tray from the tray cart, taking it to a resident room, moving the resident's over bed table, and arrange the food and table items. The staff member exited the room, returned to the tray cart and retrieved another resident's tray without performing hand hygiene. An observation was conducted on 12/8/25 at 2:18 p.m. in room [ROOM NUMBER] of a toilet that had what appeared to be feces on the front of the toilet, around the rim, and splattered on the floor. A family member in the room said neither resident can use the bathroom independently, so a staff member had to assist them. The family member was upset and said it was disgusting because the residents had to use that bathroom. An interview was conducted on 12/8/25 at 2:30 p.m. with the Director of Nursing (DON). She reviewed photos of the toilet in room [ROOM NUMBER] and said it was not acceptable, and a staff member should have cleaned that up after taking the resident to the bathroom. The DON said she would have housekeeping go clean it immediately. An observation and interview was conducted on 12/9/25 at 2:00 p.m. Water cups in multiple resident rooms were observed with no names or labels. A family member stated they had come in multiple times and their family member's over bed table had been switched with the roommates. They said the cups had no label on them, but he assumed the resident's cups were switched with the tray tables. An observation was conducted on 12/9/25 at 3:13 p.m. of a contact precaution sign hanging on the door of room [ROOM NUMBER]. A CNA observed to be in the room with only gloves on moving around the resident bed and tray table. As the CNA exited the room no hand hygiene was performed and she proceeded down the hall entering another door. Photographic Evidence Obtained. An interview was conducted on 12/9/25 at 3:18 p.m. with Staff A, CNA. Staff A confirmed she was in room [ROOM NUMBER] without Personal Protective Equipment (PPE) on and the room had a contact precaution sign. Staff A said she was not providing direct care to the resident, so she did not need to wear PPE. She said contact precautions and enhanced barrier precautions were pretty much the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Oakpark Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2851 Tampa Rd Palm Harbor, FL 34684	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	same. Staff A said some of the precaution signs have a D or W on them, which indicated which bed (door or window) in that room was on precautions. An observation was conducted on 12/10/25 at 1:41 p.m. of two staff members entering room [ROOM NUMBER] with no PPE on. The contact precautions sign remained on the door at that time. An interview was conducted on 12/11/25 at 10:23 a.m. with Staff Z, Licensed Practical Nurse (LPN). Staff Z said for a room on contact precautions staff wore a gown and gloves and for Enhanced Barrier Precautions (EBP), staff only wore gloves. An interview was conducted on 12/11/25 at 10:29 a.m. with Staff C, CNA. Staff C said if a resident was on contact precautions, staff wore a gown anytime they go in the room and EBP staff only had to wear gloves. An interview was conducted on 12/11/25 at 10:41 a.m. with Staff D, CNA. Staff D said when a resident is on contact precautions staff only wore gown and gloves when you were touching the resident and that only applied to the resident with the contact precaution orders not both residents in the room. On 12/09/2025 at 8:49 a.m., Resident #2 was observed sitting on the side of the bed. The resident stated they had an infection on their feet. The resident stated the heel protector boots have never been cleaned. Observed soiled areas on the right heel protector boot. The resident gave permission for surveyor to photograph the feet. Review of admission Records showed Resident #2 was initially admitted to the facility on [DATE] with diagnoses including but not limited to: other sequelae of cerebral infarction (I69.398), Hemiplegia, unspecified affecting right dominate side (G81.91), Dysphagia following cerebral infarction (I69.391). Review of the psychiatry progress note, dated 12/02/2025, revealed a Brief Interview for Mental Status (BIMS) score of two. This BIMS score indicated that the resident's cognition was severely impaired. An interview was conducted with Staff V, Licensed Practical Nurse (LPN) on 12/10/2025 at 3:12 pm. She stated Resident #2 has been seen by wound care, and they change the dressings on the resident's feet. She stated nurses are also removing the dressings on the resident's feet every shift. The nurses would clean the boot and sanitize daily when doing wound care. An interview was conducted with Staff U, Registered Nurse (RN) a wound care nurse, on 12/10/2025 at 3:20 pm. She stated Resident #2 has pressure sores on his elbows, left ankle, right foot and the sacrum. She said the resident is very confused and agitated all the time. She said there have been no changes in his pressure wounds. She stated, We wipe the boots every day with blue wipes. She said she monitors the resident, to ensure the boots stays on their feet. When discussing the photograph of the soiled boot, the wound care nurse stated it should have been cleaned. She noted she will wipe the boots, but she is not sure if they can be washed. Review of Resident #2's December 2025 Medical Administration Record (MAR)/Treatment Administration Record (TAR) revealed the following wound care order: Apply skin prep to bilateral heels every shift as tolerated for 14 days. The start date was 11/29/2025 at 1445. The day shift on 12/9/2025 had no treatment administration documented. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 12/11/25 at 5:01 p.m. with the Director of Nursing (DON)/Infection Preventionist (IP). The DON/IP said for a resident on contact precautions; staff sanitized their hands and put on gowns and gloves prior to entering the room. She said after providing care PPE was removed prior to exiting the room and hand hygiene was completed. The DON/IP said if a resident was on EBP staff hand sanitized prior to entering the room and wore a gown and gloves if they provided direct care to the resident. Prior to leaving the room staff removed PPE and performed hand hygiene. The DON/IP said she knew some staff did not put PPE prior to entering room and they would put it on at bedside. She said education was provided in October 2025 because the facility noticed inappropriate PPE use. The DON/IP said for hand hygiene while passing trays staff are educated to wash their hands every third tray if they are just handing the tray to someone, but if they are setting the tray up or moving anything, they should wash hands after every tray. The DON/IP said used linen in the shower rooms should be bagged up and taken to the dirty laundry. She said occasionally staff take a resident back to the room, then come clean up prior to bringing another resident in. The DON/IP said she educated staff to spray down the shower chairs then take the used linen with them when they leave the room to take the resident out. She said this allows the proper dwell time for the sanitizing and the room is ready for the next shower. The DON/IP reviewed photos of the used linen in the shower room. She said it should not have been left like that and it obviously was not ready for the next resident to be showered. The DON also reviewed photos of Resident #2's hell protector boot. She said it was disgusting and should have changed out immediately. The DON/IP said the boot looked like it had feces on it and would be an infection risk because Resident #2 had a wound on his foot. Review of a facility policy titled Transmission Based Precautions, revised 2/2024 showed: Guideline: All staff receive training on transmission-based precautions upon hire and at least annually. Procedure: 2. Contact Precautions- a. Intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident or the resident's environment. b. Make decisions regarding private room on a case-by-case basis after considering infections risks to other residents in the room and available alternatives. c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens. Review of a facility policy titled Infection Prevention and Control Program, revised 1 /2024, showed: Standard: An infection prevention and control program (IPCP) are established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Guideline: The infection prevention and control program is developed to address the facility-specific (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is based on accepted national infection prevention and control standards in accordance with local, state, and federal regulations and guidelines. Elements: 1. The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. Prevention of Infection 1. Important facets of infection prevention include: a. identifying possible infections or potential complications of existing infections; b. instituting measures to avoid complications or dissemination; c. educating staff and ensuring that they adhere to proper techniques and procedures; d. communicating the importance of standard precautions and cough etiquette to visitors and family members; e. enhancing screening for possible significant pathogens; f. immunizing residents and staff to try to prevent illness; g. implementing appropriate isolation precautions when necessary; and h. following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC (Centers for Disease Control)). Review of a facility policy titled Hand Hygiene and Infection Control, revised 6/2023, showed: Standard: Hand hygiene is the single most important measure for preventing the spread of infection. Guideline: This facility shall require facility personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated. Hand hygiene is a general term that applies to washing hands with water and either plain soap or thoroughly applying an alcohol-based hand rub (ABHR). Procedure: The facility acknowledges the CDC (Centers for Disease Control) guidelines to improve adherence to hand hygiene in health care settings. The hand hygiene guidelines are part of an overall CDC strategy to reduce infections in health care settings to promote resident safety. These guidelines state that hand washing is necessary when healthcare personnel's hands are visibly soiled. When the hands are not visibly soiled, the CDC recommends the use of alcohol-based hand rubs by health care personnel for resident care to address the obstacles that health care professionals face when taking care of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. Situations that require hand hygiene include, but are not limed to: When coming on duty When hands are visibly soiled (hand washing with soap and water) Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) Before and after performing any invasive procedure (e.g., fingerstick blood sampling) Before and after entering isolation precaution settings Before and after eating or handling food (hand washing with soap with water) Before and after assisting a resident with meals Before and after assisting a resident with personal care (e.g., oral care, bathing) Before and after handling peripheral vascular catheter and other invasive devices Before and after inserting indwelling catheters Before and after changing a dressing Upon and after coming in contact with a resident's intact skin (e.g., when taking a pulse or blood pressure, and lifting a resident) After personal use of the toilet (hand washing with soap and water) Before and after assisting a resident with toileting After contact with a resident with infectious diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella, and C.difficile (hand washing with soap and water) After blowing or wiping nose After handling soiled or used linens, dressings, bedpans, catheters and urinals. After handling soiled equipment or utensils After removing gloves or aprons After completing duty		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain essential facility equipment in a clean and safe manner within the resident environment related to 1) failing to ensure the Packaged Terminal Air Conditioners (PTAC) system filters were clean and free of debris for four resident room PTAC systems (rooms 364, 266, 272, and 210) out of seven systems observed; 2) failing to ensure the PTAC system was free from leaks in one resident room PTAC system (room [ROOM NUMBER]) out of the seven systems observed; and 3) failing to ensure the ice machines were free of bio growth in one unit ice machine (300 unit) out of four ice machines observed. Findings included: On 12/8/2025 at 10:58 a.m., the PTAC unit in room [ROOM NUMBER] was observed with a puddle of water under the unit. Photographic evidence obtained. On 12/11/2025 at 10:06 a.m. observed another large puddle of water under the PTAC unit in room [ROOM NUMBER]. Photographic evidence obtained. On 12/11/2025 at 10:06 a.m. the PTAC filters in room [ROOM NUMBER] were observed to be caked with dust and debris. On 12/11/2025 at 3:00 p.m. the PTAC filters in rooms [ROOM NUMBER] were observed with dust and debris. The vents were also noted to have dust and debris. Photographic evidence obtained. On 12/11/2025 at 10:13 a.m. an interview was conducted with Staff C, Certified Nursing Assistant (CNA). She stated the facility has a place on the computer where they can report broken machines. She said she tells maintenance directly. She stated she did not notice the leaking unit the morning of 12/11/2025 when she dropped off the food tray in room [ROOM NUMBER]. An interview was conducted with the Maintenance Director on 12/11/2025 at 2:40 p.m. She said housekeeping texts her with any maintenance issue because they do not have access to The Equipment Lifecycle System (TELS). TELS is the facility's work order system. She stated all other staff use TELS or can come to her directly. She prefers they send her the info in the TELS system. She said the PTAC filters are cleaned once a month. Review of the record labeled PTAC Air Filters Washed, revealed the 300-unit filters were last cleaned on 11/23/2025 and the 200-unit filters were last cleaned on 11/21/2025. On 12/09/2025 at 1:06 p.m. debris that appeared to be black bio growth in the 300-unit ice machine was observed. The ice machine is stored in the nourishment room for the 300 unit. The bio growth was located on the interior surface of the ice machine chute where the ice is dispensed from the machine. Black bio growth was wiped from the interior of the machine with a clean napkin during this observation. Photographic evidence obtained. An interview was conducted with the Maintenance Director on 12/09/2025 at 4:28 p.m. She stated maintenance performs monthly cleanings of the ice machines. She revealed there are cleaning logs adhered to the side of each ice machine. Review of the cleaning log for the 300 unit ice machine revealed the last cleaning was completed on 11/12/2025.		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, record review and staff interviews, the facility failed to maintain and promote dignity for two of seventy-nine sampled residents (#134 and #13), related to: 1. Staff leaving resident with meal tray in front of her for long periods of time without assistance, and leaving resident and table soiled with liquid and food for long periods of time during four of four meals observed on 12/08/2025, 12/09/2025, 12/10/2025, and 12/11/2025; and 2. Not providing or assisting with provision of clothing leaving resident to wear hospital gowns every day. Findings included: 1. On 12/8/2025 from 12:50 p.m. through to 1:25 p.m. Resident #134 was observed seated at a table in the assistive dining room. She was seated at a table with a table mate and with one staff member, Staff M Certified Nursing Assistant (CNA) in the room. Staff M was observed assisting with eating with Resident #134's tablemate. At 12:50 p.m. Resident #134 had already been served and set up with her meal and most of her food had already been pushed off the plate by her hands. Resident #134 also picked up a clear plastic cup of pink liquid and spilled it on the remaining food items on her plate. A large amount of liquid spilled all over the table, leaving a section of the tablecloth soiled. Resident #134 also had food items on her lap. There were no other staff in the room to assist and intervene with Resident #134's dining experience, and Staff M continued to assist Resident #134's tablemate only. Resident #134 sat at the table with no eating assistance or cueing, and with food and liquid all over the table and herself for over thirty-five minutes. Interview with Staff M at 12:55 p.m. revealed she was in the dining room to assist Resident #134's tablemate and did not realize Resident #134 spilled drink and pushed food off the plate. She confirmed she was seated at the same table with Resident #134 and could not answer why she did not notice what happened with the food and liquid. The tablecloth under and surrounding Resident #134's plate was soaked with liquid. Staff M did not do anything to clean up the mess, nor was she observed assisting or redirecting the resident with her meal and the mess she made. On 12/9/2025 at 12:01 p.m. Resident #134 was again observed seated at a table in the assistive section of the dining room with two other residents. She had already been served her meal and was left to eat on her own. Resident #134 grabbed at food items on her plate with her fingers and then dropped it on the floor, table and her lap. She also picked up a plastic cup of pink liquid and spilled it on her lap while attempting to drink from it. She picked up her tablemate's cup of liquid, and she spilled some of it on her plate with food items. Resident #134 was left with liquid all over her lap and food dropped on her lap for long periods of time and throughout the entire dining service. There were two other staff members in the assistive dining room Staff P, CNA and Staff Q, CNA. Both had to get up from assisting Residents #50 and #168 several times to assist other residents, leaving Residents #50 and #168 without eating assistance for several periods of time. Residents #50 and #168 were not able to be interviewed related to their meal service. On 12/9/2025 at 12:33 p.m. Staff P stated she does not normally help in the assistive dining room and (continued on next page)		

Department of Health & Human Services
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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was asked to do so today. She confirmed she and other staff had left Resident #134 without assistance for some time as she and other staff were passing and setting up meal trays for others. Staff P confirmed Resident #134 needs continued monitoring and assistance with her meal and does grab at tablemate's food and utensils. On 12/10/2025 at 8:02 a.m. Resident #134 was observed in her room lying flat in bed under the covers with her eyes closed. The over the bed table was observed placed at bedside with the breakfast meal tray placed on it. The lid was covering the plate and the meal appeared untouched. At 8:09 a.m. Staff N, Licensed Practical Nurse (LPN) confirmed Resident #134 would be eating in her room and requires total assistance with eating. Staff N was not sure who was assigned to Resident #134 to assist with eating and stated residents normally eat while in their rooms for breakfast. At 8:24 a.m. Staff M, CNA was observed to go in the room and closed the door. At 8:30 a.m. the door was opened and Staff M was observed finishing with ADL care with resident #134's roommate. Staff M revealed she will be assisting Resident #134 with her meal in a minute as she had to change the roommate's clothes and bed linen. Staff M confirmed the breakfast tray had been in the room for a little while but could not get to Resident #134 yet. Resident #134 was not assisted with her breakfast meal until 8:36 a.m., which was thirty-four minutes after staff had originally placed the meal tray on the over the bed table. At 8:55 a.m. Staff M confirmed Resident #134 needs assistance with eating and that most of the time she has to feed her, but she does try to cue the resident to pick up the utensil and eat on her own. Staff M confirmed Resident #134 does push food off her plate with her fingers and tries to pick up the food items with her fingers as well. Staff M was not sure if Resident #134 had been seen by a Speech Therapist. On 12/11/2025 at 9:00 a.m. Resident #134's was observed sitting on the side of her bed and with her breakfast meal tray placed on the over the bed table, which was positioned behind her on the other side of the bed and at the window wall. The tray could not be reached by the resident. The meal tray was still covered and appeared to not have been touched or set up by staff. At 9:16 a.m. another observation revealed the resident was still seated in the same position in bed and with her breakfast meal tray placed behind her and still not touched or assisted with set up. At 9:25 a.m. Staff P, CNA was observed going into Resident #134's room and asked Resident #134 if she wanted to eat. The resident told her, Yes. Staff P brought the tray around to the front of the resident and she sat down and set up the meal tray and began to both cue and at times assist her with eating. Resident #134 was not able to answer questions related to her dining services. Interview with Staff P at 9:40 a.m. revealed she was not able to get to Resident #134 to assist her with her meal as she had to pass trays to other residents. She confirmed the tray was in the room for a long period of time without set up and assistance and usually residents who require assistance with their meals are served and set up last. Review of Resident #134's medical record revealed she was admitted to the facility on [DATE]. Review of the advance directives revealed Resident #134 had a responsible party to make her medical and financial decisions. Review of the admission diagnosis sheet revealed diagnoses to include but not limited to: DMII, Alzheimer's disease, Anemia, Dysphagia, Conversion disorder with seizures, Insomnia, Depression. (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most current Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE], revealed; (Cognition/Brief Interview Mental Status or BIMS score 00 of 15, which indicated Resident #134 was not interviewable and would not be able to speak related to her medical care and services); (Activities of Daily Living related to EATING = Supervision and touching assistance). On 12/10/2025 at 1:10 p.m. an interview with the Director of Rehabilitation (DOR) confirmed Resident #134 does need ADL eating assistance from staff and she has been continuing with Speech Therapy since her admission. The DOR could not say how many nursing staff assist residents with eating in the assistive dining room. She did confirm it depends on what type of assistance each resident requires. The DOR confirmed Resident #134 should not be left alone with her meal to eat on her own, and does require supervision with some assistance with eating. She revealed Resident #134 has dementia and Alzheimer's and needs the extra cueing. 2. During an interview on 12/08/2025 at 1:42 p.m., Resident #13 revealed he would like some clothing. He said he had spoken to staff members, and he had told them that he would like to be transported to dialysis with clothing on instead of the hospital gown but he doesn't have any. He stated the staff members have told him multiple times they would get this done but he is still without clothing and he is transported to dialysis in a hospital gown. It was observed he was in a soiled hospital gown during this interview. An observation on 12/08/2025 at 4:00 p.m., revealed Resident #13 was still in a hospital gown and his closet was open and empty. An observation on 12/9/2025 at 1:42 p.m., Resident #13 Had no clothing in his closet. An observation on 12/10/2025 at 9:30 a.m., Resident #13 was in a hospital gown and did not have any clothing in his closet. An observation on 12/11/2025 at 11:28 a.m., and again at 6:10 p.m., Resident #13 was in a hospital gown and did not have any clothing in his closet. Resident #13 stated again he has told people he doesn't have clothes, but they haven't done anything about it he said he was not sure who else to tell. During an interview with Staff M, (CNA) on 12/10/2025 at 12:49 p.m., Staff M stated Resident #13 is in and out of the hospital a lot and he goes to Dialysis three times a week and he always wears his hospital gown. She stated that she knew he did not have any clothing and had reported it before, but she had seen no results, no clothing. She reports anything to the nurse in charge that day. Staff M provided details on how they have donated clothing residents will leave behind that can be used for anyone at any time. During an interview on 12/10/2025 at 1:13 p.m., Staff L, LPN stated that she is aware he has no clothing, and she has not reached out to the social worker about it, but she said that is a good idea and that she would do that now. Interview on 12/11/2025 at 6:00 p.m., with the Director of Activities, she stated she was not aware Resident #13 did not have any clothing. She said the process would be to contact family and see if they could bring some clothing over, but she is not sure if that has happened with this resident and she would follow up. During an interview on 12/11/2025 at 7:08 p.m., the Social Services Director said she was unaware (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that any resident did not have any clothing it had not been reported to her. She stated the expectation of this facility is if a resident comes in without clothing they would get involved and find clothing for the resident. Resident #13 has not been reported to her prior to this time. During an interview on 12/11/2025 at 7:20 p.m., the Director of Nursing (DON) reported she was not aware Resident #13 did not have any clothing. The expectation is the CNA's report that to her. Record review of Resident #13's admission Record revealed Resident #13 was re-admitted [DATE] with diagnoses to include; nonrheumatic aortic valve stenosis, end stage renal disease, hemodialysis 3x week, chronic diastolic congestive heart failure, type 2 diabetes, depressive disorder, generalized anxiety disorder, and insomnia. Review of the Minimum Data Set (MDS) assessment, dated 11/07/2025, revealed in Section C (Cognitive Patterns) the resident had a Brief Interview for Mental Status (BIMS) score of a 13 out of 15 score indicating the resident was cognitively intact. Review of the medical record revealed the Task Response History for Dressing, over the dates between 09/01/2025 - 12/10/2025 revealed Resident #13 needed extensive to total dependence assistance daily. Review of the Care Plan record for Resident #13 revealed that his Activities of Daily Living (ADL) care does not mention ADL for dressing or clothing. Review of Resident #13's Valuables Listing inventory sheet on last intake on 06/06/2025 did not indicate he had any clothing items listed. Review of the policy titled Resident Rights policy and procedure, with a last reviewed date of 1/2024 for review revealed; Standard: A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. Guideline: Employees shall treat all residents with kindness, respect, and dignity. Procedure to include but not limited to: 1. Federal and State laws guarantees certain basic rights to all residents of this facility. These rights include the resident's right to: a. A dignified experience, b. Be treated with respect, kindness, and dignity, h . Be supported by the facility in exercising his or her rights.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, facility did not ensure a resident representative was contacted immediately upon a change in condition for one resident (#178) out of three residents reviewed for change of condition. Findings included: An interview was conducted on [DATE] at 3:49 p.m. with the resident representative (RR) for Resident #178. The RR said he had been at the facility on [DATE] in the evening and Resident #178 was doing about the same as she had been doing, but her breathing was a little labored. The RR said he went home that evening and was not contacted by staff until approximately 7:30 a.m. on [DATE] letting him know Resident #178 passed away. He said he went to visit the resident every day, and staff knew he stayed with her. He said he was not contacted early in the morning when Resident #178's condition declined drastically. Review of admission Records showed Resident #178 was admitted on [DATE] with diagnoses including chronic respiratory failure, heart failure, and unspecified convulsions. Review of Resident #178's progress notes showed: [DATE] 8:27 a.m. At approx [approximately] 0415 [4:15 a.m.] this writer was informed by the assigned CNA [certified nursing assistant], that the resident had an increased effort in breathing. V/S [vital signs] as followed BP [blood pressure] 123/79, HR [heart rate] 148, O2 [oxygen saturation] 68% 8L [liters] on nasal cannula, resident switched to non rebreather with an e-tank on 10L, RR [respiratory rate] 24, temp[temperature] 98.1. Resident had been on a constant decline for the past month. Resident was repositioned to an upright position to attempt to ease her breathing, attempted suctioning with no success. Call made out to [primary care provider's] office spoke with [name] ARNP [Advanced Registered Nurse Practitioner], received new orders to obtain a CXR [chest x-ray] and administer a dose of solu-medrol 125mg [milligram] IM [intramuscular], orders implemented. Resident expired at approx 0647 [6:47 a.m.]. [name] DON, [name] ARNP, and [RR name] were all notified. IV, G-tube, catheter all removed. An interview was conducted on [DATE] at 9:51 a.m. with Staff B, Registered Nurse (RN)/Unit Manager (UM). Staff B said when a resident had a change of condition the nurse should assess the resident, call the doctor and then call the family. She said notification should happen immediately after the change of condition. Staff . said if a resident is declining and/or near death the RR should be called immediately in case they want to come be with the resident. An interview was conducted on [DATE] at 11:55 a.m. with the Nursing Home Administrator (NHA) and the Director of Nursing (DON). They said when a change of condition occurred the facility staff called the family immediately. They said if a change of condition happened in the middle of the night, staff continued to call if they didn't get an answer. The NHA and DON reviewed Resident #178's medical record and confirmed there was only documentation showing the RR for Resident #178 was called after the resident passed away. They both agreed the resident declined significantly at 4:15 a.m. on [DATE] and the RR should have been notified. The DON said she thought the nurse mentioned calling the family, but was not positive and there was no documentation showing a call was made prior to Resident #178 passing. Review of a facility policy titled Change in Resident Condition or Status-Resident Rights, revised 6/2023, showed: Standard: Facility shall notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).Guideline: To ensure the facility provides timely notification in accordance with State and Federal Regulations as it pertains to residents' rights.Procedure: 2. A significant change of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting);3. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source;b. There is a significant change in the resident's physical, (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental, or psychosocial status;c. There is a need to change the resident's room assignment;d. A decision has been made to discharge the resident from the facility; and/ore. It is necessary to transfer the resident to a hospital/treatment center.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and facility policy, the facility failed to report an allegation of abuse for two (2) residents (# 20, #166) out of five (5) residents sampled. Findings included: On 12/09/2025 at 3:00 p.m. an observation was made of Resident #20 sitting in her wheelchair propelling up and down the hallway. Resident # 20 presented a little confused but stated she had no concerns. On 12/11/2025 at 10:00 a.m. an observation was made of Resident # 20 sitting in her wheelchair propelling up and down the hallway. She said she was getting ready to go to an activity. Review of Resident # 20 admission record revealed she was admitted to the facility on [DATE] with diagnoses to include but not limited to permanent atrial fibrillation, age-related osteoporosis without current pathological fracture, cognitive communication deficit. Review of Resident # 20's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 07 which indicated Resident #20 is cognitively impaired. On 12/10/2025 at 4:00 pm an interview was conducted with Resident # 20's daughter the complainant. She stated her mother was crying when she called her on Sunday evening. The daughter stated her mother reported to her a cna was screaming at her and her roommate. She said the roommate spoke with her to confirm that the cna was yelling at her mother. The daughter said after she spoke with her mom, she called the facility around 8:57 p.m. and spoke to a staff member on the unit where her mother resided to report her concerns. She stated she told the staff what her mother and the roommate reported to her and stated she did not want the aid to return to her mother's room. The daughter stated the staff she spoke to told her they would report her concern to the nurse. 2. On 12/10/2025 at 2:30 p.m. and at 5:00 p.m., an observation was made revealing Resident # 166 sitting in her room in her wheelchair, she was observed with no signs of distress. Review of Resident # 166 admission record revealed she was admitted to the facility on [DATE] with diagnoses to include but not limited to sarcopenia, endocrine disorder, unspecified, major depressive disorder. Review of Resident # 166 Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident #166 is Intact cognitively. On 12/10/2025 at 2:50 p.m. an interview was conducted with Resident # 20 and her roommate Resident # 166. Resident # 20 stated Sunday night a staff member, she could not recall the name, came into her room and yelled at her and her roommate. Resident # 20 started crying when explaining the situation, stating that she had never been treated that way since she came to the facility. Resident # 20 said she couldn't remember all the details because she got so upset but she did tell her nurse that night what happened and the nurse told her she was going to investigate it. The roommate Resident # 166 remembered the details of the event, stating that every night she help's Resident # 20 get situated in the bed by tucking in her feet and putting an extra blanket over her legs. On Sunday night she stated that she was doing her usual routine, helping Resident # 20, when a staff member came into the room and got in her face yelling and telling her that she could not touch the resident. Resident # 166 stated the staff member pointed her finger forcefully and told her she needed to go to bed. She told the staff member that she always helps her roommate before she goes to sleep and stated the staff continued to yell at her saying that she is not to help the roommate and she needed to either go to bed or go sit in her chair. She stated that she also became emotional and started to cry because she didn't understand why she was being yelled at and felt that she had done nothing wrong. Resident # 166 stated she did not know what happened with that staff member but two ladies, she did not know their names or what their roles were, came into the room the next day and told them the staff member they had the incident with would never be assigned to them again. On 12/11/2025 at 10:26 a.m. an interview was conducted with Staff X, License Practical Nurse, (LPN). Staff X said she was the nurse assigned to Resident # 20 on Sunday night. Staff X stated Resident # 20 and # 166 did not report to her a staff member yelled at them. On 12/11/2025 at 10:30 a.m., an interview was conducted (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the Director of Nursing, DON. The DON said Staff Y, the unit manager, reported to her that she overheard one of the nurses saying she did not know anything about Resident # 20 having any issues with a staff member on Sunday night. The DON said Staff Y told her she might want to speak to Resident # 20 about a concern. The DON said Resident # 20 reported to her she was upset because a staff member was talking loudly in the hallway, but she felt safe in the facility. The DON stated she knows who the cna is the resident felt were talking loudly. She stated the cna voice carries whenever she talks, and she is very loud. The DON said they have had multiple conversations with the cna concerning her loud tone and how it could come across wrong to others. On 12/11/2025 at 11:33 a.m. an interview was conducted with Staff Y, LPN /Unit Manager on the west unit. Staff Y said she overheard one of the Registered Nurses say they did not know anything about Resident # 20 having any concerns over the weekend with her aid. Staff Y said once she overheard the conversation, she asked the Director of Nurses if she was aware of anything that happened to Resident #20 over the weekend. Staff Y stated she told the DON and maybe she should speak to the residents to see what happened. Staff Y said if she was made aware or witnessed one of the staff yelling at any of the residents, she would immediately remove the resident, remove the staff and immediately notify the Administrator or Director of Nurses. Staff Y said if a staff were yelling at a resident, it is considered verbal abuse and should be reported. On 12/11/2025 at 11:40 a.m. An interview was conducted with the Director of Nursing and the Nursing Home Administrator. The NHA stated she would have reported the certified nursing assistant if staff had reported to her the cna was yelling at Resident # 20 and #166. The DON stated she spoke to Resident # 20 yesterday and was told by the resident staff was talking loudly in the hallway. The DON said she asked Resident # 20 was she scared or harmful during her interview and was told by the resident she felt safe in the facility. The DON said she did not talk to the roommate to ask if anything happened to her because she was only told to talk to Resident # 20. The NHA said she did call Resident # 20 daughter today. The NHA stated when she spoke to the daughter, she was informed the daughter called the facility Sunday night to report to staff that her mother was crying about a cna yelling at her and her roommate. The NHA stated the daughter reported she told staff she did not want the cna assigned back to her mother. The NHA said this was the first time she was told this information. If her staff had made her aware of the incident she would have started an investigation and submitted a report. On 12/11/2025 at 12:30 p.m., an observation and interview were conducted in Residents # 20 and #166 room with the Director of Nursing and Resident # 166. The Director of Nursing asked Resident # 166 about the incident reported to them about a staff yelling at her and Resident # 20. During the interview Resident # 166 stated on Sunday she was trying to assist Resident # 20 in bed. She stated a staff member came from out the bathroom and started yelling at her and Resident # 20. She stated the staff came over to her and put her finger in her face and yelled at her, telling her to leave Resident # 20 alone, and that she should go sit down. The DON asked Resident, 166 did she tell anyone. Resident # 166 replied, I did not tell anyone because I was so upset. Resident # 166 stated two ladies came down to their room that night to tell the residents they were going to take care of the situation and the staff member who yelled at them will not be allowed back in their room. Review of the facility policy titled, Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI), Revision dated 03/2025, revealed Standards: The resident had the right to be free from abuse, neglect, exploitation, misappropriation or resident property, mistreatment, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the residents' medical symptoms. Initial Reporting: 1. In accordance with CFR 483.12 (c) (1) , with response to allegation of abuse, neglect, exploitation or mistreatment, the facility must: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that causes the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the vent that causes the allegation (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other official (including to the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility did not ensure preadmission screening for mental disorders was completed accurately for three residents (#3, #149, and #88) out of thirty-three sampled residents. Findings included: 1. Review of admission Records showed Resident #3 was admitted on [DATE] with diagnoses including dementia, depression, and bipolar disorder. Review of Resident #3's PASRR Level I Screen, dated 7/23/25, indicated the resident had depressive disorder and bipolar disorder. However, Section II was marked No for the question Does the individual have validating documentation to support the dementia or related neurocognitive disorder (including Alzheimer's disease)? An interview was conducted on 12/11/25 at 7:14 p.m. with the DON. The DON reviewed Resident #3's medical record and PASRR Level I screen. She confirmed Resident #3 had a dementia diagnosis and she should have indicated that in Section II. The DON confirmed Resident #3's PASRR Level I screen was completed inaccurately. 2. Review of the admission record showed Resident #149 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia & 6/4/25, anxiety disorder & 6/4/25, major depressive disorder & 6/4/25, and bipolar disorder & 6/4/25. A review of the Level I PASRR for resident #149, dated 8/28/25, revealed dementia as a secondary diagnosis was not selected. The review showed the Level I PASRR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. During an interview on 12/10/25 at 10:40 a.m., the Director of Nursing (DON) said on admission she reviews Level 1 PASRR's with the social worker and updates are added by the DON. The DON reported that they had reviewed Resident # 149's Level 1 PASRR and determined the resident did not meet the criteria for a Level II referral. The DON stated that the Resident #149 does not have a serious mental illness and bipolar disorder is not considered a serious mental illness. 3. Review of the admission record showed Resident #88 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia & 8/27/25, anxiety disorder & 9/24/25, major depressive disorder & 8/27/25, bipolar disorder & 9/24/25 and panic disorder 9/24/25. A review of the Level I PASARR for resident #88 dated 8/28/25 revealed not all qualifying diagnoses were selected. The review showed the Level I PASARR was incomplete, and a level II was not submitted for consideration following qualifying diagnoses. (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/11/25 at 3:33 p.m. the DON said new diagnoses should have been added to Resident #88's PASARR during the monthly gradual dose reduction (GDR) meeting. On 12/10/25 at 3:15 p.m. the Nursing Home Administrator (NHA) said the facility did not have a policy related to PASRRs, they follow the federal regulations.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide two of seventy-nine sampled residents, (#134 and #153) with Activities of Daily Living tasks to include 1. lack of Eating assistance during three meal observations and 2. lack of assistance with getting out of bed. Findings included: 1. On 12/8/2025 from 12:50 p.m. through to 1:25 p.m. Resident #134 was observed seated at a table in the assistive dining room. She was seated at a table with a table mate and with one staff member, Staff M Certified Nursing Assistant (CNA) in the room. Staff M was observed assisting with eating with Resident #134's tablemate. At 12:50 p.m. Resident #134 had already been served and set up with her meal and most of her food had already been pushed off the plate by her hands. Resident #134 also picked up a clear plastic cup of pink liquid and spilled it on the remaining food items on her plate. A large amount of liquid spilled all over the table, leaving a section of the tablecloth soiled. Resident #134 also had food items on her lap. There were no other staff in the room to assist and intervene with Resident #134's dining experience, and Staff M continued to assist Resident #134's tablemate only. Resident #134 sat at the table with no eating assistance or cueing, and with food and liquid all over the table and herself. There were no other staff observed in this section of the dining room other than Staff M. Interview with Staff M at 12:55 p.m. revealed she was in the dining room to assist Resident #134's tablemate and did not realize Resident #134 spilled drink and pushed food off the plate. She confirmed she was seated at the same table with Resident #134 and could not answer why she did not notice what happened with the food and liquid. The tablecloth under and surrounding Resident #134's plate was soaked with liquid. Staff M did not do anything to clean up the mess, nor was she observed assisting or redirecting the resident with her meal and the mess she made. On 12/9/2025 at 12:01 p.m. the main dining room was entered and there were two sections. There was a larger section of the room that had residents dining without staff assistance, and there was a smaller section that were with residents who were being assisted by staff with setting up and eating. The smaller assistive dining room area was observed with approximately 12 residents and with two staff members in seated and assisting with feeding. Resident #134 was observed seated at a table with two other residents and with no staff seated at the table or in the immediate area. Resident #134 and the two table mates were already served and set up with their lunch meal trays. Resident #134, who required more than supervision and in need for cuing and some eating assistance, was observed without staff assistance/monitoring and was grabbing at her food items with her fingers and hands. She picked up a cup full of pink liquid and was trying to bring it to her mouth and as she was doing that, liquid spilled onto the plate of food. She did not use the eating utensils that were placed next to her plate. Resident #134 then was observed to drop food from her hands onto the table and then to her lap. She was observed to pick up and drop some food at least three times. Resident #134 grabbed at her table mates silverware and Staff P, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA, walked over to the table and asked Resident #134 to not take from her table mate and to use her own eating utensils. Staff P walked away and immediately Resident #134 reached out and grabbed her tablemate's cup of pink liquid and started to drink out of it. There were no staff seated and around the table to assist and monitor Resident #134 and others at the table. There were only two staff in the dining area to include CNAs Staff P and Q, and they were either assisting passing trays to others in the room, or were seated at a table and helping to assist with feeding a resident. At 12:19 p.m. a CNA Staff P sat down to assist Resident #134 with both cueing and eating assistance. However, Staff P was observed to leave Resident #134 after assisting for about two minutes. At 12:13 p.m. the Assistant Director of Nursing was observed to bring a meal tray cart in the room and then walked over to sit next to Resident #134. She immediately began to pick up the eating utensil and brought food to Resident #134's mouth. Resident #134 accepted the bites and she was also observed to use the eating utensil with cueing. It was observed Resident #134 required both eating cueing and eating assistance, and needed full supervision so the resident would not continue to reach out and take her tablemate's food, drink and eating utensils. It was noted Resident #134 went without any supervision, cueing and or eating assistance for eight minutes, which resulted in resident spilling food and drink all over the table and spilling drink into her food. At 12:33 p.m. an interview with Staff P, CNA, who was now seated and assisting with eating with another resident at another table, revealed she does not normally help in the assistive dining room and was asked to do so today. She confirmed she and other staff had left Resident #134 without assistance for some time as she and other staff were passing and setting up meal trays for others. Staff P confirmed Resident #134 needs continued monitoring and assistance with her meal. On 12/10/2025 at 8:02 a.m. Resident #134 was observed in her room lying flat in bed under the covers with her eyes closed. The over the bed table was observed placed at bedside with the breakfast meal tray placed on it. The lid was covering the plate and the meal appeared untouched. At 8:09 a.m. the floor nurse Saff N was at her medication cart just outside the resident's room and she confirmed Resident #134 would be eating in her room and she does require total assistance with eating. Staff M was not sure who was assigned to her to assist with eating. At 8:55 a.m. Staff M confirmed Resident #134 needs assistance with eating and that most of the time she has to feed her, but she does try to cue the resident to pick up the utensil and eat on her own. It was found through three separate dining observations to include dates 12/8/2025, 12/9/2025 and 12/10/2025, Resident #134 needed more than Supervision or Touching assistance with Eating Activity of Daily Living (ADL) tasks. It was found Resident #134 had declined with Eating ADLs since last assessed. Review of Resident #134's medical record revealed she was admitted to the facility on [DATE]. Review of the advance directives revealed Resident #134 had a responsible party to make her medical and financial decisions. Review of the admission diagnosis sheet revealed diagnoses to include but not limited to: diabetes, Alzheimer's disease, anemia, dysphagia, conversion disorder with seizures, insomnia, depression. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Oakpark Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2851 Tampa Rd Palm Harbor, FL 34684	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the most current Medicare 5 day Minimum Data Set (MDS) assessment dated [DATE], revealed; (Cognition/Brief Interview Mental Status or BIMS score 00 of 15, which indicated Resident #134 was not interviewable and would not be able to speak related to her medical care and services); (Activities of Daily Living related to EATING = Supervision and touching assistance). Review of the current month (12/2025) Physician's Order Sheet revealed orders to include but not limited to: CCHO (Consistent Carbohydrate) diet, Mechanical Soft texture, Thick consistency liquids with Fortified foods at meals, with an order date 10/31/2025; Speech Therapy clarification: 3-5 x/week x 60 days of Treatment of speech, language, voice, communication, and/or auditory processing disorder and Treatment of swallowing dysfunction and/or oral function for feeding, Group Therapy and Cognition, with an order date of 10/31/2025; Weight within 72 hours of admission then weekly x 3 and then monthly, with an order date of 11/1/2025. Review of the [NAME] Admission/readmission Nursing Evaluation dated 10/31/2025 revealed in section a part D ADL/Function, Resident #134 required Limited assistance with Eating. Review of the 10/31/2025 admission Nutrition assessment revealed Resident #134 had a diagnosis of Calorie Malnutrition and Alzheimer's, admission weight of 152 lbs., no changes in weight, usual PO intake 76% 0 100%, independent with feeding assistance, and is at risk of malnutrition. Review of the Hospital Discharge assessment (form 3008), dated 10/30/2025 revealed under section Q Nutrition/Hydration &dash; Resident requires assistance with eating. Review of the nurse progress notes dated from admission on [DATE] through to current date 12/10/2025 revealed; 1. 11/6/2025 15:55 Summary of Skilled Services note revealed; Patient eats at the alcove dining room for more oversight and assistance with meals. 11/12/2025 15:47 Summary of Skilled Services note revealed; Patient eats at the alcove dining room for more oversight and assistance with meals. 11/14/202520:06 Summary of Skilled Services note revealed; Patient fed by staff with good consumption. 11/15/2025 15:29 Summary of Skilled services note revealed; Patient requires assistance with meals. 11/25/2025 15:40 Summary of Skilled services note revealed; Patient eats at the alcove dining room for more oversight and assistance with meals. 12/2/2025 16:23 Summary of Skilled services note revealed; Patient eats at the alcove dining room for more oversight and assistance with meals. Review of the current care plans with an initiated date of 10/31/2025 and with next review date 1/30/2025, revealed the following but not limited to problem/care areas; a . Resident is at risk for alteration nutrition/hydration r/t dementia, Hypertension, Hyperlipidemia, Diabetes, Hyponatremia, Anemia, poor dentation, weight loss, with interventions in place to include but not limited to: Mechanical altered diet at meals, Speech Therapy/Occupational Therapy to (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	evaluate and screen as needed or ordered; Weights as ordered. b . Resident is at risk for aspiration and or history of Aspiration r/t poor dentation, with interventions in place to include but not limited to: Encourage and assist resident to eat in upright position, Speech therapy screen/evaluation/treatment as indicated/ordered. c . Resident is participating in physical, occupational or speech therapy with a goal to improve their functional level, with interventions in place to include but not limited to: Observe for changes in Resident's Functional Abilities, Provide therapy interventions as ordered/indicated. d . Resident is at risk and or have actual impaired cognitive function/impaired thought process related to Alzheimer's dementia, with interventions in place to include but not limited to: Provide cueing and reorientation as need, Speech therapy evaluation and treatment as indicated/ordered. e . Resident has a potential for ADL self care deficit r/t ADL needs and participation vary, Fatigue, chronic medical conditions, with interventions in place to include but not limited to: Encourage and Educate resident with increased independence as tolerated and assist with all ADL tasks as indicated, including locomotion/ambulation, bathing, bed mobility, transfers, toileting, meals, etc.; EATING; The resident needs SUPERVISION verbal cues and/or touching steadying of hands to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. On 12/10/2025 at 1:00 p.m. an interview with a Speech Therapist Staff J, revealed she was knowledgeable of Resident #134 and that she has dementia/Alzheimer's, with very low cognition. Staff J explained Resident #134 has been on Speech Therapy case load since her admission and between herself and Speech Therapist Staff L, they do see her on caseload. Staff J revealed Speech Therapy will make resident assessment for eating to include chewing and swallowing safety as well as consumption and utilization of eating/drinking equipment. Staff J revealed during the times therapy is not with Resident #134, nursing staff to include aides and nurses provide eating assistance. She was not sure how many staff are in the assistive dining room during meals to assist residents with their meals. Staff J revealed based on the resident's assistive or cueing needs, direct care staff should know what they need to do assist the resident. On 12/10/2025 at 1:10 p.m. an interview with the Director of Rehabilitation (DOR) confirmed Resident #134 does need ADL eating assistance from staff and she has been continuing with Speech Therapy since her admission. The DOR could not say how many nursing staff assist residents with eating in the assistive dining room. She did confirm it depends on what type of assistance each resident requires. The DOR confirmed Resident #134 should not be left alone with her meal to eat on her own, and does require supervision with some assistance with eating. She revealed Resident #134 has dementia and Alzheimer's and needs the extra cueing. 2. On 12/09/2025 at 10:23 a.m., Resident # 153 was observed lying down in bed with her call light in reach, and no signs of distress. She stated the staff doesn't get her up when she wants to get up because they don't have enough Hoyer pads available. Resident # 153 stated she has complained to staff about it and filed a grievance, but no one at the facility addressed her concerns On 12/09/2024 at 3:00 p.m. Resident # 153 was observed lying down in bed sleeping with her call light in reach. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an admission Record dated 12/11/2025 revealed Resident # 153 was originally admitted to the facility on [DATE] with diagnoses to include but not limited to acute diastolic (congestive) heart failure, essential (primary) hypertension, unspecified glaucoma Review of a Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated Resident # 153 is cognitively intact. Review of Resident # 153 care plan dated 9/25/2024 revealed a focus for Activity of Daily Living (ADL) revealed Resident #153 has a potential for ADL self- care deficit related to (r/t) ADL needs and participation vary, chronic medical conditions, fatigue, impaired balance, limited mobility, Musculoskeletal impairment, history of coccyx fracture. Review of the care plan intervention revealed Resident # 153 transfers using a Mechanical Lift and requires two staff assistance with transfer. On 12/10/2025 at 11:38 a.m, an interview was conducted with Staff AA, CNA. Staff AA stated she is a new employee and has worked at the facility for 1 month. She has worked with Resident # 153 for the last couple of weeks and is familiar with her care. She said she gets her up every day using a Hoyer Pad/Sling. She said the only day the resident could not get up was when there was a fire in the facility, and on last Sunday when her Hoyer Pad/ Sling was in the laundry. Staff AA stated when Resident # 153 Hoyer Pad was sent to laundry, she did not have another pad available at that time to get her up. Staff AA stated the unit manager informed her today they purchased another Hoyer pad/ Sling for the resident and it's located in the shower room. On 12/10/2025 at 11:48 a.m an interview was conducted with Staff BB, Registered Nurse, RN. Staff BB stated she works at the facility as needed, and floats to different units. Staff BB said she is assigned to Resident # 153 today and her expectation is if a resident wants to get up then staff should meet the needs and desires of the resident. On 12/10/2025 at 11:54 a.m. an interview was conducted with Staff Y License Practical Nurse, LPN /Unit Manager. Staff Y stated her expectation is every resident should get out the bed. On the weekend if a resident wants to rest then it's okay for them to stay in bed. She said they have four residents on [NAME] Unit that uses the Hoyer lift. If a resident Sling/ Hoyer Pad is sent to the laundry room, then they always have extra Slings in the shower room. Staff Y stated if a staff member reports they can't get a resident up because the resident Hoyer Pad/ Sling is in laundry, then they should find someone in charge to locate one for them. A resident sling being in laundry is not an excuse to keep a resident in bed. Review of a facility policy titled, Standards and Guidelines: ADL Care and Services Revision dated 01/2024, revealed, Standard: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Guideline: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Procedure: 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) are met. 4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including, but not limited to b. Mobility (transfer, ambulation, wheelchair, splint/brace); d. Dining (meals, hydration, snacks).		

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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 reviews and interviews, the facility failed to maintain the use of a heart monitor per physician orders for one Resident (# 138) out of twenty-four residents sampled.2- An observation was conducted on 12/8/25 at 11:57 a.m. of Resident #138's room. On the bedside table there was a round silver metal device with what appeared to be electrodes on a adhesive bandage. The resident was not present in the room at the time. Review of admission Records showed Resident #138 was admitted on [DATE] with diagnoses including essential hypertension, paroxysmal atrial fibrillation and syncope and collapse. Review of Resident #138's orders showed:12/4/25-Do not remove heart monitor. Cardioresenal vision will remove in 14 days. Press button on patient chest if he has a syncopal episode. Review of Resident #138's progress notes did not show any documentation as to why the monitor was no longer in place or that a provider was notified. An interview and observation was conducted on 12/10/25 at 3:15 p.m. with Resident #138. The resident was sitting in his wheelchair at his bedside. He was pleasantly confused. When asked if he had a monitor or anything on his chest, he said he didn't think so. He was observed feeling his chest and looking down his shirt saying he didn't feel anything. An observation and interview was conducted on 12/10/25 at 3:25 p.m. with Staff E, LPN. Staff E confirmed she was assigned Resident #138 that day as well as 12/8/25, the day the monitor was observed on the bedside table. When asked if Resident #138 had a heart monitor on she said, I almost forgot about that. Staff E said she was pretty sure he only had that on for two days and it had been completed. Staff E was observed reviewing Resident #138's physician orders and said, oh it is for 14 days. Staff E said the order was from 12/4/25 and the resident should have still had the heart monitor in place, but she did not know if he did. Staff E was observed entering Resident #138's room and checking him for his heart monitor. Staff E confirmed the resident did not have a heart monitor in place. An interview was conducted on 12/10/25 at 3:31 p.m. with the Director of Nursing (DON) and Staff B, Registered Nurse (RN)/Unit Manager (UM). When asked about Resident #138 having a heart monitor in place the DON said she believe the monitor was ordered but had no come in yet. Staff B said she believed cardiology put the monitor on the resident when they saw him. The DON reviewed Resident #138's medical record and confirmed the heart monitor was placed on the resident 12/4/25 and was to remain on for 14 days. The DON said the monitor should have remained in place and not been removed. She reviewed the photo of the device seen on the resident's bedside table on 12/8/25 and said that it was the heart monitor. An interview was conducted on 12/10/25 at 3:43 p.m. with the Cardiology Nurse Practitioner (NP). The NP confirmed she placed a heart monitor on Resident #138 on 12/4/25 due to him having episodes of syncope. She said the monitor should have remained in place for 14 days, not coming off for showers or any reason. The NP said the device is very difficult to remove and she had never had one come off or a resident be able to remove it. The NP said the round silver metal disc stored the data from the heart and the device was sent to the company who produced a report for the data. She said the device should not have been removed from the resident and she was never contacted by the facility letting her know the device was no longer on the resident. The NP said she would be in the facility the next day and would have to try to locate the monitor. She said she did not know if they would have to begin the test over because this has never happened before. The NP was going to assess the resident and go from there. Review of a facility policy titled Standards and Guidelines: Physician Orders, revised 1/2024, showed:Guideline: Orders and administration of medications and treatments will be consistent with principles of safe and effective order writing.Procedure: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. Photographic evidence obtained		