

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation for complaint number 2025001896 was conducted from _____ to _____ at Lake Haven Nursing and Rehabilitation, in conjunction with second revisit to a recertification survey (L10V13), a second revisit to a Federal Monitoring Health Comparative survey (7L9X13), and a revisit to a complaint survey for complaint #2025000067 (VLSU12). The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities. Previously cited deficiencies were found to be corrected related to the second revisit to a Federal Monitoring Health Comparative survey (7L9X13), the second revisit to the recertification survey (L10V13), and the revisit to the complaint investigation (VLSU12). However, a new deficiency was identified during the complaint survey (O50L11). The facility has been out of compliance since _____.	F 000		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide a therapeutic diet according to physician orders for two _____.	F 808	Facility denies and disputes the validity of this citation and completes this POC solely	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

/2025

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 and plans 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	<p>Continued From page 1</p> <p>residents (#1 and #25) out of four residents reviewed.</p> <p>Findings included:</p> <p>1.</p> <p>Review of Resident #1's "Admission Record" revealed he was admitted to the facility on from an acute care hospital with medical diagnoses of _____ due to _____ of left _____, _____ and _____ following _____ affecting right dominant side, _____ following _____, and _____.</p> <p>An interview was conducted on _____ at 10:30 a.m. with Resident #1. He was observed sitting in the main dining room at a table watching television. He raised his _____ and told Staff D, Certified Nursing Assistant (CNA) he wanted coffee and a snack. Staff D, CNA said I am going to get him a snack because he was in _____ during snack time. She was observed going to another room off the main dining area and obtained a soft cookie and placed it on the coffee cart. Staff D, CNA was overheard asking another staff member what Resident #1's diet was and the other staff member said he needed thickened liquids. Staff D, CNA prepared Resident #1's coffee with nectar thickener and provided it to Resident #1. He did not receive a snack.</p> <p>An interview was conducted on _____ at 10:54 a.m. with Resident #1. Resident #1 was observed with no snack in front of him. He said, "I haven't gotten my snack. She's giving me the run around.</p>	F 808	<p>to meet the requirements of State licensure and Federal regulations. Facility further denies any and all statements, acknowledgements, confirmations, or comments attributed to facility staff as strictly hearsay.</p> <p>(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Identified resident #1 Resident was provided an additional serving of protein during lunch meal service per physician order Diet orders were reviewed by the Chief Nursing Officer _____ Tray ticket updated with Puree diet per physician order and Speech recommendations _____ Resident did not suffer any adverse effects r/t not receiving the proper diet texture. Resident # 1 was assessed by the APRN _____ APRN progress notes documented: _____ CTA, No _____, chills or increased in _____ or _____ No decrease in SPO2 noted.</p> <p>Identified resident #25 was provided an additional serving of protein per physician order during lunch meal service _____ /205.</p> <p>(2) How you will identify other residents</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 808	<p>Continued From page 2</p> <p>It's my snack and I want it, I'm hungry."</p> <p>Review of Resident #1's _____ physician orders revealed an order with a start date of _____ and no stop date, "NAS/CCD [no added salt/carb-controlled diet], pureed texture, Nectar/Mildly thick consistency. Double portion protein/entrée each meal."</p> <p>An interview was conducted on _____ at 11:26 a.m. with Staff D, CNA. She said for residents who are on pureed diets, they can have pudding for a snack. She said Resident #1 asked her for a snack "a while ago" but she was not sure what his diet order was. She said she could ask his nurse but she didn't want to leave all the residents in the dining area unsupervised. She said she could wait until he gets his lunch tray to see what kind of diet he has and then give him a snack at that time. She said to the resident's lunch will arrive at "11:30 a.m."</p> <p>A lunch observation was conducted on _____ at 11:35 a.m. Resident #1 was observed sitting in the main dining room with a plate of sliced carrots, a scoop of scalloped potatoes, and ground beef with gravy on it.</p> <p>An interview was conducted on _____ at 11:36 a.m. with Staff E, Registered Nurse (RN). She said she is in the dining room helping out because the other nurse was on break. She confirmed she gave Resident #1 his meal tray and she observed his lunch plate and said he received mechanical soft food, and she was not sure if it was double portions of protein or not. She obtained his meal</p>	F 808	<p>having potential to be affected by the same practice and what corrective actions will be taken;</p> <p>Quality review completed _____ by Certified Dietary Manager/designee to ensure the residents receive meals per physician order, tray tickets match the physician order and residents receive double portions/2x entr_ e.</p> <p>Quality review completed by the DON/designee r/t ensuring residents are provided with snacks when requested to be completed</p> <p>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p> <p>Dietary staff re-educated by the Certified Dietary Manager on the components of this regulation and that residents receive meals per physician order, tray tickets match the physician order, tray line validates what is served match the tray ticket and residents receive double portions/2x entr_ e. When the Dietary Manger is not present the dietary staff will update the sheet located in the kitchen to document new admissions, re-admissions or diet changes and update the pre-printed tickets with changes, _____ write a ticket with new admissions /re-admissions for the Dietary Manger to input in the tray card system upon return to the center completed</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 808	<p>Continued From page 3</p> <p>ticket and confirmed the meal ticket said, "Double protein mechanical soft with nectar thick liquids".</p> <p>An interview was conducted on _____ at 11:50 a.m. with the Director of Nursing (DON). She said _____ will assess a resident and make recommendations for their diet order and, "I have to approve it", then nursing will put the order into the medical record and a dietary communication form is completed and given to someone in the kitchen, then we follow up with the Dietary Manager to ensure they are aware of the change in the diet order.</p> <p>An interview was conducted on _____ at 11:52 a.m. with the Dietary Manager. She said when a diet is changed a dietary communication form is filled out and given, "to me, and I make sure the order is changed in the system." She said she also reviews residents' medical records every day, and sometimes twice a day, for any dietary changes. The Dietary Manager confirmed Resident #1 received a mechanical soft diet for lunch and confirmed she provided him with an extra portion of mechanically soft textured meat. She said she was not here yesterday (_____) and was not aware Resident #1's diet changed to puree and said that was a problem. She asked Staff F, Corporate Travelling RN, if Resident #1 was on a puree diet and she said, "yes, his diet was downgraded yesterday" and Staff F, Corporate Travelling RN told the dietary manger to get the Speech _____ to sit with the resident.</p> <p>An interview was conducted on _____ at 11:59 a.m. with the Speech _____. She said Resident #1 was at high risk for _____ and he</p>	F 808	<p>Current Certified Nursing Assistants re-educated by the DON/designee r/t ensuring residents receive snacks upon request to be completed</p> <p>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;</p> <p>Certified Dietary Manager /designee to conduct ongoing quality monitoring through visual observation of the tray line and meal service in the dining room to ensure residents are provided meals per physician order 5 x weekly x 4 weeks, 3x weekly x 4 weeks, twice weekly x 4 weeks then weekly and PRN as indicated.</p> <p>DON/designee to conduct ongoing quality monitoring through resident interview and observation to ensure snacks are provided upon request 3 x weekly x 2 weeks, twice weekly x 2 weeks then weekly and PRN as indicated.</p> <p>The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 2 months then quarterly and PRN as indicated and modified based on findings.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 808	<p>Continued From page 4</p> <p>was on a mechanical soft diet with thickened liquids, but she trialed him with a peanut butter and jelly sandwich yesterday () and he immediately started coughing, so she downgraded his diet to puree because she didn't want him on a mechanical soft diet and someone giving him a sandwich because of his risk for . She said when she changed his diet, she filled out the diet change slip and gave it to, "a guy in the kitchen." She said Resident #1 does well when his food is all mixed together and when he eats, he automatically mixes it all together. She said he is a resident who will eat anything and everything and you have to watch out for him because he is on a pureed diet but he will eat anything.</p> <p>Review of Resident #1's physician notes dated revealed "... following ST [] to following - discussed with ST, will maintain puree diet at this time on pureed diet with moderately thick liquid Nursing to assist with feeds as needed."</p> <p>A follow up interview was conducted on 3:38 p.m. with the Dietary Manager. She said the dietary electronic system is different from the medical record, so in order for diets to get updated on the meal tickets she relies on the dietary change forms, and she did not receive a dietary change form for Resident #1. She said someone handed the dietary change form to the dishwasher yesterday and from there the form is missing and the dietary system did not get updated.</p> <p>2.</p> <p>On at 10:53 a.m., an interview was conducted with Resident #25, while seated in the</p>	F 808			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 808	<p>Continued From page 5</p> <p>main dining room. He said he was supposed to get double portions with his food items but has not been getting double portions. Resident #25 revealed he used to get four pieces of toast, then he got three, then two, and now he gets no toast at breakfast at all. He continued to say he only gets one scoop of eggs for breakfast as well and he is continually hungry and he keeps losing and is not getting double portions like he is supposed to.</p> <p>On at 11:30 a.m. the main dining room was observed for the lunch meal service. During the observation, there were approximately twenty residents seated at various tables, all being assisted by six staff members with their meal trays. Staff were observed removing meal trays from tray carts and placing the trays on tables in front of the residents. Staff were identified lifting the trays and setting up the meal per resident choice and the need for assistance.</p> <p>At 11:38 a.m., Resident #25 was observed seated at a table and already received his lunch tray. Observations of his lunch tray included what appeared to be one small "Salisbury steak" patty covered with brown gravy, a small scoop of what appeared to be cheese potatoes, and six small carrot slices. Resident #25 also received two small plastic cups of red liquid juice and one plastic wrapped cookie. It appeared all the food items were a "Regular" texture base. Resident #25 did not receive "double portions" with any of the food items. Review of the lunch meal ticket positioned next to the resident's tray revealed, "Double Protein", which was highlighted in yellow, and regular diet No Added Salt (NAS). The ticket did</p>	F 808			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 808	<p>Continued From page 6</p> <p>not have any dislikes noted. (Photographic Evidence Obtained)</p> <p>An interview was conducted on _____ at 11:42 a.m. with the CDM. She reviewed Resident #25's lunch meal ticket and plate of food and confirmed he should have received two pieces of the Salisbury steak and he did not.</p> <p>A review of Resident #25's medical record revealed he was admitted to the facility on _____ Review of the admission diagnosis sheet revealed diagnoses to include but not limited to _____ and need for assistance with personal care.</p> <p>Review of Resident #25's _____ physician orders revealed the following:</p> <ol style="list-style-type: none"> Healthy Diet, Regular Texture, Regular/thin consistency - Double Portion meat/entrée at each meal for diet, order date _____ Med Pass 2.0 [three times a day] 120 ml [milliliters] record % consumed, order date _____ <p>Review of Resident #25's Progress Notes and Registered Dietician Assessment/Notes, with look period from _____, revealed:</p> <ul style="list-style-type: none"> - A _____ Change Note dated _____ at 5:00 p.m., _____ % in 30 days. Diet is NAS regular, thin liquid. Will add Med Pass 2.0 supplements, 120 ml _____ and also double portion meat/entre each meal. Will follow as need. - A _____ Change Note dated _____ /205 at 2:15 p.m., _____ has become more stabilized and is _____ Diet is NAS, regular, thin liquid. Double portion entree was added last month when he had _____ 	F 808			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 808	<p>Continued From page 7</p> <p>loss. His [] 25. - 7.5% lost. Med Pass 2.0 PO [by] 120 ml was put in place due to loss he had last month. Will follow as need.</p> <p>On at 2:20 p.m., an interview with the facility's Registered Dietician (RD), who has been employed as the RD for about 6 months. She revealed she was aware Resident #25's loss upon his readmission from the hospital on . She also revealed she had interventions to include double portions for protein as well as Med Pass three times a day to increase . She noted Resident #25 generally consumes 75 to 100% of meals and although Resident #25 has had some loss, she continues to monitor his and he is stable and within his range. She continued to say she will keep Med Pass and Double Portions for him. The RD reviewed the photo of the resident's lunch meal and she confirmed he did not receive double portion for meat. She revealed he should have received two patties instead of one and the meal ticket also revealed, "double portion". The RD confirmed the CDM and the tray line staff should have caught that today and followed the meal ticket/order. She revealed there are times she is at the tray line and she supervises and reviews tickets as to what is served on tray line.</p> <p>Review of Resident #25's current care plans, with a next review date , revealed the following: - Resident has nutritional problem or potential nutrition problem of having unplanned loss with interventions in place to include but not limited to: Provide and serve supplement as ordered; Provide and serve diet as ordered (double</p>	F 808			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 808	<p>Continued From page 8</p> <p>portions entrée each meal); Monitor and record each meal; RD to evaluate and make diet changes as recommended and as need; Weigh per protocol.</p> <p>On at 7:15 a.m. an interview and observation was conducted with the CDM in the facility kitchen, where she demonstrated the meal service process in the kitchen. Staff A, Cook, Staff B, Cook in training, Staff C, Dietary Aide, and the CDM, all were getting ready to plate and send out breakfast meal trays to residents. The CDM revealed either the day before or a couple of days prior, Staff A, Cook will receive paper meal tickets and place them in a pile on the steam table counter area. The CDM also revealed Staff A, Cook or whoever is the cook for the day will review each ticket one a time as the plate is being prepared. The CDM revealed the Staff A, Cook reads meal ticket and looks out for things to include the type of diet, type of texture, likes and dislikes, adaptive eating equipment, and also if double portions are ordered. She revealed if the meal ticket says double portions, the cook for the day will honor the meal ticket and plate as read. She revealed "double portions" would be defined as two times the normal scoop for soft food items and double portions of other items such as steak or chicken. For the breakfast meal, the double portion would be two hard boiled eggs instead of one, a scoop size of six ounces of hot cereal instead of two, and double cups of liquid.</p> <p>Staff A, Cook confirmed the process the CDM explained and is the process he follows. The CDM further revealed when the meal tray is plated, the Dietary Aide, in this case Staff C, Dietary Aide, will</p>	F 808			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 808	<p>Continued From page 9</p> <p>review the meal ticket and plated food items for accuracy. Staff C, Dietary Aide confirmed she looks at all the food items on the meal tray and the meal ticket to determine if the cook provided the right diet and menu items.</p> <p>The CDM also revealed that she monitors the tray line for the breakfast and lunch meal service, many of the dinner meal services, and at times during the weekends. The CDM revealed the cook on assignment when she is not at the facility is the person who is responsible for reviewing the meal tickets and following them for accuracy.</p> <p>Further interview with Staff A, Cook and Staff C, Dietary Aide, who both worked on _____ in the kitchen, confirmed they did not know how several plates of food got out to residents that did not follow the meal ticket. Staff A, Cook and Staff C, Dietary Aide also confirmed they found out Resident #25 and a couple of other residents did not receive double portions as per their meal ticket order for the lunch meal service. The CDM also confirmed that should not have happened and she was not sure how the meal tickets were not followed.</p> <p>On _____, the Nursing Home Administrator, Director of Nursing, and the CDM all confirmed the facility did not have a "Following/honoring meal tickets/diets" policy and procedure for review.</p>	F 808			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS A complaint investigation for complaint number 2025001896 was conducted from ... to at Lake Haven Nursing and Rehabilitation, in conjunction with second revisit to a recertification survey (L10V13), a second revisit to a Federal Monitoring Health Comparative survey (7L9X13), and a revisit to a complaint survey for complaint #2025000067 (VLSU12). Previously cited deficiencies were found to be corrected related to the second revisit to a Federal Monitoring Health Comparative survey (7L9X13), the second revisit to the recertification survey (L10V13), and the revisit to the complaint investigation (VLSU12). However, a new deficiency was identified during the complaint survey (O50L11).	N 000		
N 407 SS=D	400.141(1)(i), FS Dietary Services Every licensed facility shall comply with all applicable standards and rules of the agency and shall: (i) If the licensee furnishes food service, provide a wholesome and nourishing diet sufficient to meet generally accepted standards of proper nutrition for its residents and provide such therapeutic diets as may be prescribed by attending physicians. In making rules to implement this paragraph, the agency shall be guided by standards recommended by nationally recognized professional groups and associations with knowledge of dietetics. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide a therapeutic	N 407	Facility denies and disputes the validity of this citation and completes this POC solely	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

/25

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
--------------------------------------------------	-----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698
-------------------------------------------------------------------------	---------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

N 407	<p>Continued From page 1</p> <p>diet according to physician orders for two residents (#1 and #25) out of four residents reviewed.</p> <p>Findings included:</p> <p>1.</p> <p>Review of Resident #1's "Admission Record" revealed he was admitted to the facility on from an acute care hospital with medical diagnoses of _____ due to _____ of left _____ and _____ following _____ affecting right dominant side, _____ following _____ and _____.</p> <p>An interview was conducted on _____ at 10:30 a.m. with Resident #1. He was observed sitting in the main dining room at a table watching television. He raised his _____ and told Staff D, Certified Nursing Assistant (CNA) he wanted coffee and a snack. Staff D, CNA said I am going to get him a snack because he was in _____ during snack time. She was observed going to another room off the main dining area and obtained a soft cookie and placed it on the coffee cart. Staff D, CNA was overheard asking another staff member what Resident #1's diet was and the other staff member said he needed thickened liquids. Staff D, CNA prepared Resident #1's coffee with nectar thickener and provided it to Resident #1. He did not receive a snack.</p> <p>An interview was conducted on _____ at 10:54 a.m. with Resident #1. Resident #1 was observed with no snack in front of him. He said, "I haven't gotten my snack. She's giving me the run around.</p>	N 407	<p>to meet the requirements of State licensure and Federal regulations. Facility further denies any and all statements, acknowledgements, confirmations, or comments attributed to facility staff as strictly hearsay.</p> <p>(1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>Identified resident #1 Resident was provided an additional serving of protein during lunch meal service per physician order Diet orders were reviewed by the Chief Nursing Officer _____ Tray ticket updated with Puree diet per physician order and Speech recommendations Resident did not suffer any adverse effects r/t not receiving the proper diet texture. Resident # 1 was assessed by the APRN _____ APRN progress notes documented: _____ CTA, No _____, chills or increased in _____ or _____. No decrease in SPO2 noted.</p> <p>Identified resident #25 was provided an additional serving of protein per physician order during lunch meal service _____ /205.</p> <p>(2) How you will identify other residents having potential to be affected by the same practice and what corrective actions will be taken;</p>	
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 407	<p>Continued From page 2</p> <p>It's my snack and I want it, I'm hungry."</p> <p>Review of Resident #1's _____ physician orders revealed an order with a start date of _____ and no stop date, "NAS/CCD [no added salt/carb-controlled diet], pureed texture, Nectar/Mildly thick consistency. Double portion protein/entrée each meal."</p> <p>An interview was conducted on _____ at 11:26 a.m. with Staff D, CNA. She said for residents who are on pureed diets, they can have pudding for a snack. She said Resident #1 asked her for a snack "a while ago" but she was not sure what his diet order was. She said she could ask his nurse but she didn't want to leave all the residents in the dining area unsupervised. She said she could wait until he gets his lunch tray to see what kind of diet he has and then give him a snack at that time. She said to the resident's lunch will arrive at "11:30 a.m."</p> <p>A lunch observation was conducted on _____ at 11:35 a.m. Resident #1 was observed sitting in the main dining room with a plate of sliced carrots, a scoop of scalloped potatoes, and ground beef with gravy on it.</p> <p>An interview was conducted on _____ at 11:36 a.m. with Staff E, Registered Nurse (RN). She said she is in the dining room helping out because the other nurse was on break. She confirmed she gave Resident #1 his meal tray and she observed his lunch plate and said he received mechanical soft food, and she was not sure if it was double portions of protein or not. She obtained his meal ticket and confirmed the meal ticket said, "Double</p>	N 407	<p>Quality review completed _____ by Certified Dietary Manager/designee to ensure the residents receive meals per physician order, tray tickets match the physician order and residents receive double portions/2x entr_ē.</p> <p>Quality review completed by the DON/designee r/t ensuring residents are provided with snacks when requested to be completed</p> <p>(3) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur;</p> <p>Dietary staff re-educated by the Certified Dietary Manager on the components of this regulation and that residents receive meals per physician order, tray tickets match the physician order, tray line validates what is served match the tray ticket and residents receive double portions/2x entr_ē. When the Dietary Manger is not present the dietary staff will update the sheet located in the kitchen to document new admissions, re-admissions or diet changes and update the pre-printed tickets with changes, write a ticket with new admissions /re-admissions for the Dietary Manger to input in the tray card system upon return to the center completed</p> <p>Current Certified Nursing Assistants re-educated by the DON/designee r/t ensuring residents receive snacks upon request to be completed</p>		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 407	<p>Continued From page 3</p> <p>protein mechanical soft with nectar thick liquids".</p> <p>An interview was conducted on _____ at 11:50 a.m. with the Director of Nursing (DON). She said _____ will assess a resident and make recommendations for their diet order and, "I have to approve it", then nursing will put the order into the medical record and a dietary communication form is completed and given to someone in the kitchen, then we follow up with the Dietary Manager to ensure they are aware of the change in the diet order.</p> <p>An interview was conducted on _____ at 11:52 a.m. with the Dietary Manager. She said when a diet is changed a dietary communication form is filled out and given, "to me, and I make sure the order is changed in the system." She said she also reviews residents' medical records every day, and sometimes twice a day, for any dietary changes. The Dietary Manager confirmed Resident #1 received a mechanical soft diet for lunch and confirmed she provided him with an extra portion of mechanically soft textured meat. She said she was not here yesterday (_____) and was not aware Resident #1's diet changed to puree and said that was a problem. She asked Staff F, Corporate Traveling RN, if Resident #1 was on a puree diet and she said, "yes, his diet was downgraded yesterday" and Staff F, Corporate Traveling RN told the dietary manger to get the Speech _____ to sit with the resident.</p> <p>An interview was conducted on _____ at 11:59 a.m. with the Speech _____. She said Resident #1 was at high risk for _____ and he was on a mechanical soft diet with thickened liquids, but she trialed him with a peanut butter</p>	N 407	<p>(4) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put in place;</p> <p>Certified Dietary Manager /designee to conduct ongoing quality monitoring through visual observation of the tray line and meal service in the dining room to ensure residents are provided meals per physician order 5 x weekly x 4 weeks, 3x weekly x 4 weeks, twice weekly x 4 weeks then weekly and PRN as indicated.</p> <p>DON/designee to conduct ongoing quality monitoring through resident interview and observation to ensure snacks are provided upon request 3 x weekly x 2 weeks, twice weekly x 2 weeks then weekly and PRN as indicated.</p> <p>The findings of these quality reviews will be reported to the Quality Assurance/Performance Improvement Committee monthly x 2 months then quarterly and PRN as indicated and modified based on findings.</p>		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 407	<p>Continued From page 4</p> <p>and jelly sandwich yesterday () and he immediately started coughing, so she downgraded his diet to puree because she didn't want him on a mechanical soft diet and someone giving him a sandwich because of his risk for . She said when she changed his diet, she filled out the diet change slip and gave it to, "a guy in the kitchen." She said Resident #1 does well when his food is all mixed together and when he eats, he automatically mixes it all together. She said he is a resident who will eat anything and everything and you have to watch out for him because he is on a pureed diet but he will eat anything.</p> <p>Review of Resident #1's physician notes dated revealed "... following ST [,] to following - discussed with ST, will maintain puree diet at this time on pureed diet with moderately thick liquid Nursing to assist with feeds as needed."</p> <p>A follow up interview was conducted on 3:38 p.m. with the Dietary Manager. She said the dietary electronic system is different from the medical record, so in order for diets to get updated on the meal tickets she relies on the dietary change forms, and she did not receive a dietary change form for Resident #1. She said someone handed the dietary change form to the dishwasher yesterday and from there the form is missing and the dietary system did not get updated.</p> <p>2.</p> <p>On at 10:53 a.m., an interview was conducted with Resident #25, while seated in the main dining room. He said he was supposed to get double portions with his food items but has not</p>	N 407			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
--------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698
--------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 407	<p>Continued From page 5</p> <p>been getting double portions. Resident #25 revealed he used to get four pieces of toast, then he got three, then two, and now he gets no toast at breakfast at all. He continued to say he only gets one scoop of eggs for breakfast as well and he is continually hungry and he keeps losing _____ and is not getting double portions like he is supposed to.</p> <p>On _____ at 11:30 a.m. the main dining room was observed for the lunch meal service. During the observation, there were approximately twenty residents seated at various tables, all being assisted by six staff members with their meal trays. Staff were observed removing meal trays from tray carts and placing the trays on tables in front of the residents. Staff were identified lifting lids to the trays and setting up the meal per resident choice and the need for assistance.</p> <p>At 11:38 a.m., Resident #25 was observed seated at a table and already received his lunch tray. Observations of his lunch tray included what appeared to be one small "Salisbury steak" patty covered with brown gravy, a small scoop of what appeared to be cheese potatoes, and six small carrot slices. Resident #25 also received two small plastic cups of red liquid juice and one plastic wrapped cookie. It appeared all the food items were a "Regular" texture base. Resident #25 did not receive "double portions" with any of the food items. Review of the lunch meal ticket positioned next to the resident's tray revealed, "Double Protein", which was highlighted in yellow, and regular diet No Added Salt (NAS). The ticket did not have any dislikes noted. (Photographic Evidence Obtained)</p>	N 407		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
--------------------------------------------------	-----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698
-------------------------------------------------------------------------	---------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 407	<p>Continued From page 6</p> <p>An interview was conducted on _____ at 11:42 a.m. with the CDM. She reviewed Resident #25's lunch meal ticket and plate of food and confirmed he should have received two pieces of the Salisbury steak and he did not.</p> <p>A review of Resident #25's medical record revealed he was admitted to the facility on _____.</p> <p>Review of the admission diagnosis sheet revealed diagnoses to include but not limited to _____ and need for assistance with personal care.</p> <p>Review of Resident #25's _____ physician orders revealed the following:</p> <ol style="list-style-type: none"> 1. Healthy Diet, Regular Texture, Regular/thin consistency - Double Portion meat/entrée at each meal for diet, order date _____ 2. Med Pass 2.0 [three times a day] 120 ml [milliliters] record % consumed, order date _____ <p>Review of Resident #25's Progress Notes and Registered Dietician Assessment/Notes, with look period from _____, revealed:</p> <ul style="list-style-type: none"> - A _____ Change Note dated _____ at 5:00 p.m., _____ % in 30 days. Diet is NAS regular, thin liquid. Will add Med Pass 2.0 supplements, 120 ml and also double portion meat/entrée each meal. Will follow as need. - A _____ Change Note dated /205 at 2:15 p.m., _____ has become more stabilized and is _____ Diet is NAS, regular, thin liquid. Double portion entree was added last month when he had _____ loss. His [] 25. - 7.5% lost. Med Pass 2.0 PO [by] 120 ml was put in place due to _____ loss he had last month. Will follow as need. 	N 407		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
--------------------------------------------------	-----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698
-------------------------------------------------------------------------	---------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 407	<p>Continued From page 7</p> <p>On at 2:20 p.m., an interview with the facility's Registered Dietician (RD), who has been employed as the RD for about 6 months. She revealed she was aware Resident #25's loss upon his readmission from the hospital on . She also revealed she had interventions to include double portions for protein as well as Med Pass three times a day to increase . She noted Resident #25 generally consumes 75 to 100% of meals and although Resident #25 has had some loss, she continues to monitor his and he is stable and within his range. She continued to say she will keep Med Pass and Double Portions for him. The RD reviewed the photo of the resident's lunch meal and she confirmed he did not receive double portion for meat. She revealed he should have received two patties instead of one and the meal ticket also revealed, "double portion". The RD confirmed the CDM and the tray line staff should have caught that today and followed the meal ticket/order. She revealed there are times she is at the tray line and she supervises and reviews tickets as to what is served on tray line.</p> <p>Review of Resident #25's current care plans, with a next review date , revealed the following: - Resident has nutritional problem or potential nutrition problem of having unplanned loss with interventions in place to include but not limited to: Provide and serve supplement as ordered; Provide and serve diet as ordered (double portions entrée each meal); Monitor and record each meal; RD to evaluate and make diet changes as recommended and as need; Weigh per protocol.</p>	N 407		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/27/2025
--------------------------------------------------	-----------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698
-------------------------------------------------------------------------	---------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 407	<p>Continued From page 8</p> <p>On at 7:15 a.m. an interview and observation was conducted with the CDM in the facility kitchen, where she demonstrated the meal service process in the kitchen. Staff A, Cook, Staff B, Cook in training, Staff C, Dietary Aide, and the CDM, all were getting ready to plate and send out breakfast meal trays to residents. The CDM revealed either the day before or a couple of days prior. Staff A, Cook will receive paper meal tickets and place them in a pile on the steam table counter area. The CDM also revealed Staff A, Cook or whoever is the cook for the day will review each ticket one a time as the plate is being prepared. The CDM revealed the Staff A, Cook reads meal ticket and looks out for things to include the type of diet, type of texture, likes and dislikes, adaptive eating equipment, and also if double portions are ordered. She revealed if the meal ticket says double portions, the cook for the day will honor the meal ticket and plate as read. She revealed "double portions" would be defined as two times the normal scoop for soft food items and double portions of other items such as steak or chicken. For the breakfast meal, the double portion would be two hard boiled eggs instead of one, a scoop size of six ounces of hot cereal instead of two, and double cups of liquid.</p> <p>Staff A, Cook confirmed the process the CDM explained and is the process he follows. The CDM further revealed when the meal tray is plated, the Dietary Aide, in this case Staff C, Dietary Aide, will review the meal ticket and plated food items for accuracy. Staff C, Dietary Aide confirmed she looks at all the food items on the meal tray and the meal ticket to determine if the cook provided the right diet and menu items.</p> <p>The CDM also revealed that she monitors the tray</p>	N 407		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55221	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2025
NAME OF PROVIDER OR SUPPLIER LAKE HAVEN NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 SAN CHRISTOPHER DR DUNEDIN, FL 34698		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 407	Continued From page 9 line for the breakfast and lunch meal service, many of the dinner meal services, and at times during the weekends. The CDM revealed the cook on assignment when she is not at the facility is the person who is responsible for reviewing the meal tickets and following them for accuracy. Further interview with Staff A, Cook and Staff C, Dietary Aide, who both worked on in the kitchen, confirmed they did not know how several plates of food got out to residents that did not follow the meal ticket. Staff A, Cook and Staff C, Dietary Aide also confirmed they found out Resident #25 and a couple of other residents did not receive double portions as per their meal ticket order for the lunch meal service. The CDM also confirmed that should not have happened and she was not sure how the meal tickets were not followed. On , the Nursing Home Administrator, Director of Nursing, and the CDM all confirmed the facility did not have a "Following/honoring meal tickets/diets" policy and procedure for review. Class III	N 407			