STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105268	A. Building B. Wing	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Health Center	2501 N Australian Avenue West Palm Beach, FL 33407

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36734 Based on record review and interview, the facility failed to protect the resident's right to be free from physical abuse for 1 of 2 sampled residents (Resident #3) by a resident (Resident #2) with a history of physical abuse to staff and other residents. This is evident by the lack of supervision of Resident #2, contributing to re-offended physical abuse towards Resident #3. The findings included: Review of the closed record for Resident #2 revealed the resident was admitted to the facility on [DATE] with diagnoses which included Dementia, Adjustment Disorder with Anxiety, and Major Depressive Disorder. Further review revealed a comprehensive assessment dated [DATE] that documented the resident had severe cognitive impairment and required substantial/maximum assistance with activities of daily living. Resident #2 was transferred to the hospital on 09/05/24 for weight loss and functional decline per family request. Resident #2 was care planned for physically aggressive/combative behaviors with interventions included: administer medications as ordered, psych consult as indicated, and document observed behaviors and attempted interventions. Resident #3 was admitted to the facility on [DATE] with diagnoses which included Dementia. Record review revealed a comprehensive assessment dated [DATE] that documented the resident had severe cognitive impairment and required partial/moderate assistance with activities of daily living. A review of Resident #2's progress notes revealed a note, dated 08/18/24 at 3:54 PM, that documented: Received report from resident (Resident #3) that a naked man came in her room and hit her with his fist. CNA (Certified Nurse Assistant) confirmed that this resident (Resident #2) was naked and removed from other resident's (Resident #3) room after hearing the resident call for help. Resident unable to give description. Resident assessed, no new injuries noted, family and NP (Nurse Practitioner) notified. A progress note dated 08/20/24 at 4:02 PM documented: This writer received report from CNA that she heard another resident (roommate of Resident #2) yell for help, upon entering the room she found this resident (Resident #2) over other resident (the roommate) with bed remote in hand, in the striking position, removed this resident (Resident #2) from resident's (roommate of Resident #2) room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress noted dated 08/22/24 at 2:57 PM documented: IDT (Interdisciplinary Team) Meeting: [Resident #2] discussed in meeting in regards to resident's behaviors. Psych was in to see resident, medication adjustment made. Team placed call to resident's family member to discuss resident's behaviors, team discussed with family member the need for one-on-one supervision. Family member stated he would discuss with family and let us know. Team stressed the importance of having a one on one. Family member stated he would be in today to discuss further. A progress note dated 08/23/24 at 11:13 AM documented: SSD (Social Services Director) and writer called resident's (Resident #2) family member to follow up about conversation in regarding to one on one. Family member stated that he is discussing with other family members. We offered private sitters. SSD to forward information on agencies. We reiterated the significance of the one-to-one companionship need for his safety and other. Provided information on the disease process. Family member voiced concerns in regard to other residents wandering into the resident's room, it was explained to Family member that it is common to have residents wander due to cognitive impairments, but the resident (Resident #2) is experiencing aggression and can be sexually inappropriate. Previous incidents have occurred in other resident's room where the resident (Resident #2) has wandered into. Family member verbalized understanding and stated that he would get back to us no later than Monday. A progress note dated 08/28/24 at 1:40 PM documented: Placed call to resident's (Resident #2) family member in regard to resident's behavior and incident that occurred with another resident (Resident #3). A review of Resident #3's progress notes revealed a noted dated 08/18/24 at 12:06 PM documented: This writer attempted to assist resident in eating and resident expressed that she did not want to eat much due to pain in her mouth. I was sleeping, and I heard some noises, I woke up and the man (Resident #2) didn't have no clothed on, and he started to hit me on my face. This writer asked resident to open her mouth to assess, bruising noted on the inside of the left side of bottom lips, skin assessment completed, no other visible injuries noted, vitals stable, PRN (as needed) pain medication administered, NP (Nurse Practitioner) notified, family notified. A progress notes for Resident #3 dated 08/28/24 at 1:51 PM documented: Received report that resident was on the floor in east hallway, resident observed on buttocks sitting against the wall. Resident Description: He (Resident #2) came in my room and started to take off his clothes. I told him to stop. Jehovah would not want you to do this. I got up and left the room. He followed me and pushed me down and I fell . Resident assessed and assisted to get up with the help of other staff member. Resident was assisted to recliner inside room, head to toe skin assessment completed, no injuries noted, resident complained of slight pain to left arm, PRN administered, ROM completed without difficulty, able to move all extremities, stop sign banner in place, NP and Daughter notified. An interview was conducted with the Social Services Director (SSD)/Abuse Coordinator on 09/09/24 at 2:30 PM. The SSD stated Resident #2 was declining cognitively. The resident had become much more aggressive and had more behaviors. The resident gets physical with staff and other residents. The facility had multiple conversations with family regarding the resident's decline. The facility provided 1:1 supervision as short term/couple of days. Resident #2's family had agreed to come in on a rotating basis. The family stopped showing up. They looked at low-cost companionship and provided the family with a list of agencies. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 09/09/24 at 3:00 PM. The DON acknowledged the lack of supervision of Resident #2 contributed to the physical abuse of Resident #3. The DON acknowledged it was the facility's responsibility to keep their residents free from abuse.