

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: 105268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Lakeside Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to implement a care plan for residents with a diagnosis of Post Traumatic Stress Disorder (PTSD) for 2 of 2 sampled residents (Resident #4 and #91). The findings included: A review of the facility's Behavioral Health Services policy, last reviewed on 09/02/25, documented the facility will provide behavioral health care and services that create an environment that promotes emotional and psychosocial well-being, meets each resident's needs, and includes individualized approaches to care. Under procedure it was documented to complete the nursing assessment and social services assessment upon admission/readmission, quarterly, and as needed with changing condition. Through this assessment the facility should identify residents to ensure an accurate diagnosis of a mental disorder or psychosocial adjustment difficulty, or PTSD was made by a qualified professional. Initiate behavior monitoring, behavior management care plan, and kardex as indicated by assessment findings, use of psychoactive medications, resident/responsible party conversations, and observations. The social worker is primarily responsible for initiation of the behavior management care plan. 1. Record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses that included PTSD. A comprehensive assessment dated [DATE] documented the resident had moderate cognitive impairment, was independent for activities of daily, and had a primary medical condition of PTSD. A review of Resident #4's care plan did not address the resident's diagnosis of PTSD, including the cause and triggers the resident may exhibit. An interview was conducted with the Social Service Director (SSD) on 12/17/25 at 12:00 PM. The SSD acknowledged the findings. 2) Record review revealed Resident #91 was admitted to the facility on [DATE]. Further review of the record revealed that Resident #91's diagnosis included in part, Chronic Obstructive Pulmonary Disease (COPD), Bipolar Disorder and Post Traumatic Stress Disorder (PTSD). A review of Resident #91's care plan did not address the resident's diagnosis of PTSD, including the cause and triggers the resident may exhibit. An interview was conducted with the Social Service Director (SSD) on 12/17/25 at 3:40 PM. The SSD acknowledged the findgs.		

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
--	-------	-----------

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: 105268	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2025
NAME OF PROVIDER OR SUPPLIER Lakeside Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to document a change in a resident's condition for 1 of 1 sampled resident reviewed for respiratory infection (Resident #74). The findings included: A review of the facility's policy titled, Changes in Resident's Condition or Status, last reviewed 08/29/25, documented in part: Documentation associated with identifying and communicating a change in a resident's status includes: date and time of procedure, acute change in status, behavioral changes, vital signs, oxygen saturation level, other assessment findings in the appropriate areas in the residence medical record, nursing interventions, and communication with healthcare team members. Record review revealed Resident #74 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had severe cognitive impairment and required partial A moderate assistance with activities of daily living. A review of Resident #74's care plan revealed a care plans, dated 12/15/25, that documented the resident is on antibiotic therapy related to an Upper Respiratory Infection (URI). A review of Resident #74's physician orders revealed an order dated 12/12/25 for Amoxicillin, (an antibiotic), 500 milligrams by mouth every 12 hours for URI for 7 days. A review of Resident #74's progress notes dated 12/05/25-12/13/25 did not reveal any indications or symptoms of the resident having an URI. A review of residence #74's vital signs revealed no indication of the Resident having an infection. A review of Resident #74's progress notes revealed a progress note dated 12/14/25 that documented the resident was receiving Amoxicillin 500 milligrams by mouth every 12 hours for URI for 7 days and was tolerating well. An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 12:00 PM. The DON acknowledged the above and stated she would look into it. A follow up interview was conducted with the DON on 12/18/25 at 1:00 PM. The [NAME] stated that Resident #74 was seen by the Nurse Practitioner (NP) on 12/12/25 and provided documentation of such visit (not in resident's record). A review of the NP's progress note dated 12/12/25 at 9:30 AM documented: Patient (Resident #74) was seen today for ongoing issues with upper respiratory signs and symptoms. Staff reported increased nasal drainage and cough a few days ago and due to patient history of allergies he was started on Zyrtec (allergy medication). Today patient has ongoing worsening signs and symptoms and has some complaints of nasal congestion with the drainage along with not much improvement in cough. Patient has no fevers, has history of recurrent sinus infections. Plan: Amoxicillin 500 milligrams two times a day for 7 days, continue allergy medications, follow up any non- resolved signs and symptoms.		