STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105466	A. Building B. Wing	10/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Beach Nursing Center	4405 Lakewood Road Lake Worth, FL 33461

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 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 record reviews and interviews the facility failed to coordinate the care ordered by the podiatrist for 1 of 3 sampled residents (Resident #2). The findings included:Review of the record revealed that Resident #2 was admitted to the facility on [DATE]. Review of the diagnosis revealed a documented history of Type 2 diabetes with left foot ulcer, chronic osteomyelitis (infection in bone), and right below the knee amputation. During an interview with Resident #2's daughter on 10/28/25 at 1:45 PM, she stated that she was concerned because her father is healing from an amputation of his left toes. She stated that she scheduled a follow up appointment for the resident to be seen be the podiatrist on 10/27/25 and he missed the appointment, because the nurse forgot to make arrangements for transportation. The resident's daughter stated I am concerned about the delay in care. My father was supposed to have surgical debridement done but the facility failed to do what was needed for medical clearance. During an interview with the Administrator on 10/28/25 at 1:20 PM, the podiatry visit notes for Resident #2 were requested. She stated, They should be uploaded on the resident's record. She was made aware that no podiatry notes were found on the resident's chart.During an interview on 10/28/25 at 3:32 PM, the administrator stated that she had to call the podiatrist office to get copies of the visit notes, because they could not locate them. She provided copies of the visit notes for 09/22/25 to 10/17/25.Review of the podiatry visit note dated 10/03/25, documented a plan that new dressing orders were given and Resident #2 was to follow up in 2 weeks.Review of the physician orders for Resident #2 did not reveal any updated wound care orders as of 10/03/25. Review of the podiatry visit note dated 10/17/25, revealed documentation by the podiatrist that stated suspect pseudomonas infection of the left foot wound and further surgical debridement is warranted at this time, a script for medical clearance and cephalexin. The plan was for Resident #2 to have surgical debridement within the next 7-14 days pending medical clearance.During an interview on 10/28/25 at 4:30 PM, the first floor Unit Manager was asked to view the progress note for 10/03/25. When asked were orders sent with visit note, she looked in the resident's record and stated I don't know. The only wound care order for Resident #2 is from 09/18/25. She was asked to view the visit note dated 10/17/25 and was asked if she knew where the script for medical clearance and the cephalexin was that was given with the visit note, shed stated, I wasn't aware of this. The Unit Manger was asked what the process was when the resident had a doctor's appointment and returned with paperwork, she stated Either me or the nurse will review the paperwork and input any orders. When asked what if the resident returns from a doctor's appointment without any paperwork what would you do, she stated I would call the doctor's office to follow up.During an interview with the ADON (Assistant Director of Nursing), when asked what the process is when a resident has a doctor's appointment and returns with paperwork, she stated, The nurse should review the paperwork and put in any orders given. When asked what if the resident returns without paperwork, she stated the nurse should call the doctor's office to make sure no new orders were given.

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