

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: 105640	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER North Lake Care Center and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 750 Bayberry Drive Lake Park, FL 33403	
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 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 observation, interview, policy and record review, the facility failed to inform the physician of a significant weight loss for 1 of 3 sampled residents reviewed for nutrition, Resident #6. The findings included: Review of the facility's policy titled Change in a Resident's Condition or Status revised February 2021, revealed Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. Review of the facility's policy titled Weight Assessment and Intervention revised March 2022 revealed The threshold for significant unplanned and undesired weight loss will be based on the following criteria 1 month -5% weight loss is significant; greater than 5% is severe. Record review revealed Resident #6 was initially admitted to the facility on [DATE] with diagnoses that included Heart Failure, Type 2 Diabetes Mellitus and Peripheral Vascular Disease. Review of the resident's quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 06/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. On 08/04/25, the resident was weighed, and the weight was documented as 237.5 pounds. On 09/02/25, the resident was weighed and documented as weighing 223 pounds. This indicated a 5.91% weight loss. The resident's re-weight was not in the electronic health record. An interview was conducted with Staff G, Registered Dietician / RD, on 09/10/25 at 11:49 AM who stated the resident takes Lasix (a diuretic) and it is expected the resident would have weight fluctuation with gradual weight loss. An interview was conducted with Staff F (RD) on 09/11/25 at 12:10 PM. She stated she comes to the facility once a week on a Thursday. She has been working in this facility for 3 months and has not yet met the resident. She stated Resident #6 was weighed on Tuesday 09/02/25 in the morning, she was aware of the weight the month prior, and she requested a re-weigh. They did the reweigh on the same day (09/04/25) but she had already left the facility. She stated that she should see the resident and do another assessment. Once she saw him, she would have a team meeting and proceed from there. She would see the resident and talk to him and see if the weight was desirable. She would notify the Physician after talking to the resident. She would look at the prior documentation and look at the weight trends. She agreed that it is a long time to wait a week to notify the physician. An interview was conducted with the Medical Director on 09/11/25 at 11:30 AM who stated that he would want to be informed of a resident's significant weight loss right away. An interview was conducted with the Nurse Practitioner on 09/11/25 at 1:05 PM who stated she would have liked to know as soon as the staff knew that the resident had a significant weight loss.		

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report and resolve a grievance for 1 of 1 sampled resident reviewed for grievances, Resident #11. The findings included:Record review revealed Resident #11 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident was cognitively intact and required partial/moderate assistance with activities of daily living.Record review revealed Resident #11 was care planned on 04/23/25 for self-care deficit with dressing, grooming, and bathing as evidenced by needs set up to supervision with personal care tasks due to generalized weakness, and limited endurance. An intervention included to provide staff assistance with dressing, grooming, bathing as needed. An interview was conducted with Resident #11 on 09/08/25 at 11:30 AM. Resident #11 stated he had had concerns over the the care he receives on 2nd shift (3-11 PM). The resident stated they are slow to respond to his call light, and they are rude in responding. A subsequent interview was conducted with Resident #11 on 09/10/25 at 10:00 AM. Resident #11 asked if the surveyor had inquired about the lack of treatment and slow response to the call bell on 2nd shift. Resident #11 stated he had reported it multiple times to the guy that comes to his room almost every morning and he had not received a response or seen a change. An interview was conducted with the Director of Housekeeping on 09/10/25 at 10:30 AM. The Director stated he was assigned as the ambassador to Resident #11's room and communicates with the resident on a daily basis. The Director acknowledged that Resident #11 had expressed concerns with care and call light response time on the 2nd shift. The Director stated he brought it to the attention of the Director of Nursing (DON) and Administrator during morning meetings approximately a month ago, but could not give a definitive date. Review of the facility's grievance log did not indicate a grievance for Resident #11 regarding concerns with care and call light response time on the 2nd shift within the past 3 months review. An interview was conducted with the DON on 09/10/25 at 12:00 PM. The DON acknowledged awareness of Resident #11's concerns with 2nd shift's care and call light response time. The DON further stated she did not complete a grievance for Resident #11.		

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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 record review and interview, the facility failed to obtain labs as ordered and failed to notify the physician of the missed labs for 1 of 1 sampled resident, Resident #54. The findings included:Record review revealed Resident #54 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and required partial/moderate assist with activities of daily living.Review of Resident #54's orders revealed an order dated 09/03/25 for, Urinalysis with reflex to culture, CBC (Complete Blood Count) with differential, BMP (Basic Metabolic Profile) in AM [morning]. Further review of Resident #54's record revealed the urine culture, CBC, and BMP were not conducted or obtained. Further review of Resident #54's record did not reveal any indication the physician was notified of the missed labs. An interview was conducted with the Director of Nursing (DON) on 09/10/23 at 12:00 PM. The DON acknowledged the above. The DON further stated it was missed.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete and have dialysis communication forms post treatment for 1 of 1 sampled resident reviewed for dialysis, Resident #3. The findings included: Record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses included End Stage Renal Disease (ESRD). A comprehensive assessment dated [DATE] documented the resident had moderate cognitive deficit and required supervision for activities of daily living. The assessment further indicated the resident received dialysis. Review of Resident #3 care plan documented the resident was care planned on 08/11/25 for potential for complications related to hemodialysis for treatment of ESRD, receives dialysis on: Tuesday and Saturday. An intervention included to complete dialysis communicate tool on dialysis days and review upon return from dialysis. Review of Resident #3's Dialysis Communication Interchange forms revealed missing dialysis communication forms for 08/12/25, 08/30/25, and 09/02/25. Further review of the dialysis communication forms revealed the section labeled Facility Nurse Complete Below When Resident Returns From Dialysis (an assessment of the resident) was not completed for 08/16/25, 08/19/25, 08/23/25, and 08/26/25. An interview was conducted with Resident #3's nurse, Staff I, Registered Nurse, on 09/11/25 at 12:00 PM. Staff I acknowledged the above and stated the resident leaves the facility with the form to go to dialysis, and it is expected that the resident return with the form to review and complete the assessment post treatment.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, record review and observation, the facility failed to appropriately reconcile controlled medications for 2 of 4 sampled residents reviewed for medication reconciliation, Resident #1 and Resident #16. The findings included: Review of the facility's policy titled Controlled Substances, publication date and revision date not supplied, under the heading of Policy Interpretation and Implementation, documented, in part: Under that section is the subsection with the heading Dispensing and Reconciling Controlled Substances. Item 1 documented: Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. Item 2 documented: The system of reconciling the receipt, dispensing, and disposition of controlled substances includes the following: Records or personnel access and usage. Medication administration records. Declining inventory records; and Destruction, waste, and return to pharmacy records. On 09/11/25 at 12:28 PM, an observation was made of the DIV 4 med cart [Division 4's medication cart] with Staff A, Licensed Practical Nurse (LPN). A review of the Controlled Substance Log was conducted for Resident #16. The medication identified on the Controlled Substance Log was Tramadol 100 mg (milligram) tablets. The instruction on the label stated: 1 tablet by mouth 3 times daily as needed. The pharmacy issue date was 06/15/25. The amount delivered to the facility was 30 tablets. The first dose was on 06/21/25 at 8:00 AM. The most recent dose recorded was on 08/20/25 at 2100 (9:00 PM). The medication dosing card had 21 tablets remaining. The count on the Controlled Substance Log had 21 tablets remaining. Review of the Medication Administration Record (MAR) for Resident #16 revealed a dose was administered on 09/04/25 at 2051 (8:51PM). This dose was not recorded on the Controlled Substance Log for Resident #16. On 09/11/25 at 1:35 PM, an observation was made of the DIV 1 med cart with Staff B, LPN. A review of the Controlled Substance Log was conducted for Resident #1. The medication identified on the Controlled Substance Log was Oxycodone IR 15 mg 1 Tab by mouth every 6 hours as needed for non-acute pain. The pharmacy issue date was 09/05/25. The amount delivered was 24 tablets. The first dose was on 09/05/25 at 10:05 PM. The medication dosing card had 9 tablets remaining. The count on the Controlled Substance Log had 9 tablets remaining. The most recent dose on the Controlled Substance Log was for 09/11/25 at 11:00 AM. Review of the MAR for Resident #1 revealed no entries for the 09/11/25 at 11:00 AM dose administered. The last MAR entry was for 09/10/25 at 2033 (8:33 PM). On 9/11/25 at approximately 2:30 PM, an interview was conducted with the Director of Nursing (DON). The DON agreed that there should not be discrepancies with Controlled Substance administration and documentation. The DON stated she would immediately begin in-service training with the nurses regarding reconciliation of Controlled Substances, and investigate the discrepancies identified by the surveyor.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and maintain policies and procedures for the monthly drug regimen review that included, but are not limited to, time frames for the different steps in the process for 2 of 5 sampled residents sampled for unnecessary medications, Residents #2 and #5. The findings included: Review of the facility's policy titled, Tapering Medications and Gradual Drug Dose Reduction with a revised date of April 2025 included in part the following: Tapering/GDR (Gradual Dose Reduction) may be used as an approach to finding an optimal dose or determining if continued use of a medication will benefit the resident. In addition, the staff and practitioner consider GDR under certain circumstances including when: a) the resident's clinical condition has improved or stabilized, b) the underlying causes of the original target symptoms have resolved, c) non-pharmacological interventions, including behavioral interventions, have been effective in reducing symptoms; or d) a resident's condition has not responded to treatment or has declined despite treatment. Within the first year after a resident is admitted on a psychotropic medication or after the resident has been started on a psychotropic medication, the staff and practitioner will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. Review of the facility's policy titled, Medication Regimen Reviews with a revised date of May 2019 included in part the following: The medication regimen review (MRR) involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems, medication errors and other irregularities for example: c) duplicative therapies or omissions of ordered medication, h) other medication errors, including those related to documentation. If the Physician does not provide a timely or adequate response, or the Consultant Pharmacist identifies that no action has been taken, he/she contacts the Medical Director or (if the Medical Director is the physician of record) the Administrator. 1.) Record review revealed Resident #5 was originally admitted [DATE] with most recent readmission on [DATE] and diagnoses that included in part the following: Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation and Major Depressive Disorder Recurrent Moderate. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status score of 13 indicating an intact cognitive response. Review of the Physician's Orders for Resident #5 revealed in part the following: An order dated 02/21/25 for Trazodone HCl oral tablet 100mg give 1 tablet by mouth at bedtime and was discontinued on 06/22/25. An order dated 06/25/25 for Trazodone HCl oral tablet 100mg give 1 tablet by mouth at bedtime was discontinued on 07/20/25. An order dated 07/20/25 for Trazodone HCl oral tablet 100mg give 1.5 tablet by mouth at bedtime. Review of the Consultant Pharmacist Recommendation to the Physician for Resident #5 dated 05/06/25 documented, Federal guidelines stated that antidepressant drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in 2 different quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood or treat psych disorder. This resident has been taking Trazadone 100mg every bedtime since 11/16/24 without a GDR. Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? [Staff D] Advance Practice Registered Nurse (APRN) response dated 05/09/25 documented to decrease to 75mg tab oral every bedtime for depression. The order to attempt a GDR by decreasing the dosage of the Trazadone was never entered into the resident's chart. An interview was conducted on 09/10/25 at 4:15 PM with the Director of Nursing (DON) who was asked about the Consultant Pharmacist Recommendation to the Physician. She stated the recommendations are kept by herself, but she does not review them, but that the Physician/Nurse Practitioner are to put their own orders in the resident's chart. The DON stated the Consultant Pharmacist will review the residents' medications the following month. When asked about the Consultant Pharmacist Recommendation to Physician for Resident #5 dated (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/06/25 the DON stated as of 07/20/25 the Trazadone has been increased because patient symptoms have increased, so the order to decrease the Trazadone in May is null and void.2. Record review for Resident #2 revealed the resident was originally admitted to the facility 08/10/23 with a most recent readmission on [DATE] with diagnoses that included in part the following: Acute Chronic Diastolic (Congestive) Heart Failure, Type 2 Diabetes Mellitus, Generalized Anxiety Disorder and Major Depressive Disorder. The MDS assessment dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating an intact cognitive response. Review of the Physician's Orders for Resident #2 revealed in part the following:An order dated 02/19/25 for Pantoprazole Sodium oral tablet delayed release 40mg give 1 tablet by mouth at bedtime was discontinued on 08/19/25 (entered into the electronic medical record by Staff E, Advanced Practitioner Registered Nurse / APRN).An order dated 08/18/25 for Pantoprazole Sodium oral tablet delayed release 20mg give 1 tablet by mouth at bedtime (entered into the electronic medical record by Staff E). Review of the Consultant Pharmacist Documentation regarding Recommendations included in part the following:Review of the Consultant Pharmacist Recommendation to the Physician for Resident #2 dated 06/06/25 documented this resident has been taking Pantoprazole 40mg at bedtime since 02/19/25 without a dose reduction. Please consider a trial dose reduction to Pantoprazole 20mg at bedtime. Staff E, APRN, response dated 06/11/25 was to reduce dose of Pantoprazole to 20mg oral daily.Review of the Listing of residents 'Reviewed with No Recommendations' for recommendation created between 07/01/25 and 07/08/25 listed Resident #2.Review of the Consultant Pharmacist Recommendation to the Physician for Resident #2 dated 08/07/25 documented this resident has been taking Pantoprazole 40mg at bedtime since 02/19/25 without a dose reduction. Please consider a trial dose reduction to Pantoprazole 20mg at bedtime. Staff E Advanced Practice Registered Nurse (APRN) response dated 08/19/25 was to reduce dose of Pantoprazole to 20mg oral at bedtime.The order to reduce the dose of Pantoprazole from 40mg to 20mg at bedtime documented on 06/11/25 was never entered into Resident #2's chart. Additionally, it was not addressed in by the Consultant Pharmacist in the July 2025 report. An interview was conducted on 09/10/25 at 4:15 PM with the Director Of Nursing (DON) who was asked about the Consultant Pharmacist Recommendation to Physician in June 2025 for Resident #2,. The DON stated the ARNP who responded to the recommendation is supposed to enter their own orders. When asked if she reviews the responses to the recommendations, the DON said no she does not. An interview was conducted on 09/11/25 at 12:55 PM with Staff E, APRN, who was asked about the Consultant Pharmacist Recommendation to the Physician. Staff E stated they are given to me by the DON, I fill them out and give them back to the DON. It is my assumption she (the DON) puts the orders in (the resident's chart).		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to initiate behavior monitoring for 1 of 5 sampled residents reviewed for unnecessary medications, Resident #6. The findings included: Record review revealed Resident #6 was initially admitted to the facility on [DATE] with diagnoses that included Heart Failure, Type 2 Diabetes Mellitus and Peripheral Vascular Disease. Review of the resident's quarterly Minimum Data Set (MDS) assessment with an assessment reference date of 06/25/25, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating an intact cognitively intact. Review of the Physician order's revealed on 09/05/25 the resident was started on Quetiapine Fumarate 25 milligrams (mg) tablet to give 1 tablet by mouth two times a day for psychosis. On 09/10/25, Quetiapine Fumarate was increased to 50 mg at bedtime related to schizoaffective disorder. Review of the physician's orders revealed no behavior monitoring order for this medication since the start of the medication. AN interview was conducted with the Director of Nursing (DON) on 09/11/25 at 2:00 PM related to the no behavior monitoring being done for the antipsychotic medication. The DON acknowledged this. Behavior monitoring was added to Medication Administration Record (MAR) after surveyor intervention on 09/11/25.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to secure medications at all times for 1 of 21 sampled residents with medications observed at the bedside, Residents #42. The findings included: Review of the facility's policy titled, Storage of Medications with no date included in part the following: The facility stores all drugs and biologicals in a safe, secure and orderly manner. Review of the facility's policy titled, Self-Administer of Medications with no date included in part the following: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Record review for Resident #42 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Unspecified Adrenocortical Insufficiency, Anxiety Disorder and Unspecified Glaucoma. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status (BIMS) score of 15 indicating an intact cognitive response. Review of Physician's Orders for Resident #42 revealed in part the following: An order dated 09/10/24 for Triamcinolone Acetonide external cream 0.5 % apply to affected areas topically every 12 hours as needed for eczema rash and apply to affected areas topically every day and night shift for eczema rash for 14 days. An order dated 08/22/24 for Hydrophilic External ointment apply to dry skin topically two times a day for Dry Skin. An order dated 07/25/25 for Aquaphor External ointment apply to dry skin areas topically every day and night shift for eczema. Review of the Self Administration of Medication assessment for Resident #42 dated 08/27/25 documented the resident did not express a desire to self-administer medication or treatments. Review of the Self Administration of Medication assessment for Resident #42 dated 09/10/25 documented the resident did not express desire to self-administer medication or treatments. On 09/08/25 at 10:30 AM, an observation was made of hydrocortisone cream 1% on the over bed table next to the resident sitting up in bed. An interview was conducted on 09/08/25 at 10:30 AM with Resident #42 who was asked about the hydrocortisone cream 1% on the over bed table. He stated that it is for his eczema. On 09/09/25 at 10:00 AM, a second observation with another surveyor was made of hydrocortisone cream 1% on the over bed table next to Resident #42 sitting up in bed. An interview was conducted on 09/10/25 at 1:00 PM with the Director of Nursing (DON) who was asked about residents having medications at the bedside. She stated the resident should be assessed for self-administration and if they are safe to do so, they could have the medications at the bedside but would need to keep the medications locked. The DON acknowledged they have a severely cognitively impaired resident with behaviors that included wandering into other resident's rooms and has taken various items from those resident's rooms and often attempting to eat inappropriate items. An interview was conducted on 09/10/25 at 1:45 PM with the DON who acknowledged Resident #42 had Hydrocortisone cream on his overbed table. She removed the cream and stated the resident had a different cream ordered for the same issue.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to have an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use for 1 of 1 sampled resident reviewed for infection, Resident #54. The findings included: Record review revealed Resident #54 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented the resident had mild cognitive impairment and required partial/moderate assist with activities of daily living. Resident #54 had diagnoses including Dysuria (difficulty urinating) and Benign Prostatic Hyperplasia (BPH, enlarged prostate). Record review revealed Resident #54 was care planned for alteration in elimination as evidence by frequent incontinence of bladder and bowel, impaired mobility, and difficulty with urine stream due to diagnosis of BPH, at risk for UTI (Urinary Tract Infection). Interventions included; administer medications as ordered, observe for effectiveness and for side effects, observe for signs and symptoms of UTI, report to physician if noted, and labs as ordered, report results to physician. Resident #54 was observed and communicated with by surveyor on 09/08/25, 09/09/25, and 09/10/25 without concerns. An interview was conducted with Resident #54 on 09/10/25 at 9:30 AM. The resident was observed in bed with a new intravenous (IV) line on the right arm. The surveyor inquired about the IV line, and Resident #54 stated the line was placed this morning for some kind of an infection. Review of Resident #54's physician orders revealed an order dated 09/03/25 for Urinalysis with reflex to culture, CBC (Complete Blood Count) with differential, BMP (Basic Metabolic Profile) in am. There was also an order for Ciprofloxacin [antibiotic] 250 milligrams every 12 hours for UTI for 5 days (start date 09/04/25). Further review of Resident #54's record revealed the urine culture, CBC, and BMP were not conducted or obtained on 09/04/25 as ordered. Further review of Resident #54's physician orders revealed orders dated 09/09/25 to place a mid-line (IV) and to start IV antibiotics every 24 hours for 7 days UTI / pyelonephritis (kidney infection) for 7 Days. There was also an order for a urinalysis with culture, CBC, and BMP. Further review of Resident #54's chart did not reveal any indications of the resident having pain or difficulty urinating, or increased temperature. An interview was conducted with the Nurse Practitioner (NP) on 09/10/25 at 11:00 AM. The NP stated Resident #54 had completed antibiotic therapy on 09/09/25, and continued to be symptomatic. The NP acknowledged that the initial urine culture ordered 09/03/25 was not completed, and the ordered CBC and BMP were not completed, which would have helped to determine if the resident had an infection, and which antibiotic, if needed, would be effective. The NP stated she examined Resident #54 on 09/09/25, and he presented with flank pain. An interview was conducted with Staff H, Registered Nurse/RN, on 09/10/25 at 2:00 PM. Staff I stated Resident #54 had not complained of any pain. Staff I further stated if the resident had pain, it would be documented in the resident's progress notes, and the resident had Tylenol prescribed for pain, which Staff I confirmed the resident had not received any pain medication. An interview was conducted with the Medical Director on 09/10/25 at 1:00 PM. The Medical Director stated based on the information he received from the NP, the treatment was appropriate. An interview was conducted with the Director of Nursing (DON) and the Infection Control Preventionist (ICP) on 09/10/25 at 2:00 PM. The DON and ICP stated Resident #54 did not meet the criteria for antibiotic stewardship. They stated the NP ordered it, so it was given. They acknowledged if there was a concern with antibiotic use, they should notify the physician / Medical Director. Review of a progress note dated 09/10/25 at 4:34 PM by the NP documented: Urinalysis (UA) and Labs reviewed with physician. UA results not consistent with UTI at this time post Cipro (antibiotic completion). Few bacteria are noted and culture is pending. He remains afebrile. Resident received x 1 dose of Rocephin (antibiotic) IV secondary to suspicion for pyelonephritis / persistent UTI. Recommendations to stop Rocephin at this time. NP notified physician also that midline infiltrated RUE [right upper extremity/arm] and has been removed by nursing staff. Initially orders were given to reinsert however orders have been given to discontinue orders for reinsertion. He denies any pain at this time in RUE or left flank.		