

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455903	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Lake Lodge Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3800 Marina Dr Lake Worth, TX 76135	

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. (continued on next page)

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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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interviews and record reviews, the facility failed to protect residents' right to personal privacy and confidentiality of his or her personal and medical records for 10 of 74 residents (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8, Resident #9, Resident #10) reviewed for confidentiality of records. CNA A provided a list containing residents' names and medical appointment details to Resident #1. This failure could place residents at risk for psychosocial damage, emotional damage and potential fraudulent. Findings included: Record review of facility's incident investigation, dated 8/4/2025, revealed CNA A, who was the facility's transport person, gave a list of residents' names and their appointments to Resident #1. The list included the following information: Resident #2's Magnetic Resonance Imaging (MRI) appointment. Resident #3's orthopedic (bone & joint specialist) appointment. Resident #4's podiatry (foot specialist) appointment. Resident #5's orthopedic appointment. Resident #6's podiatry appointment. Resident #7's pain management appointment. Resident #8's pulmonary (lung specialist) appointment. Resident #9's urology (urinary specialist) appointment. Resident #10's nephrology (kidney specialist) appointment. Resident #1's dermatology (skin specialist) appointment. In an interview on 9/4/2025 at 9:35am, Resident #1 stated that CNA A gave him a list of resident's appointments that were missed because she was suspended by the facility pending investigation involving damage to facility's transport van. He stated that CNA A wanted him to give the list to the volunteer Ombudsman. Record review of Resident #1's MDS assessment, dated 8/2/2025, revealed his BIMS score was 15, indicating intact cognitive state. In an interview on 9/4/2025 at 11:15am, CNA A stated she gave the list to Resident #1 to give it to the volunteer Ombudsman. She stated that she understood that she breached residents' confidentiality by doing that. She stated that she felt Resident #1 was trustworthy and would not discuss other residents' information, so she gave him the list. In an interview on 9/5/2025 at 10:30am, the volunteer Ombudsman stated that he did not receive any list from CNA A. He stated that due to the suspension of CNA A, he went to the facility on 8/5/2025 to discuss alternative options with residents to ensure there was an alternative form of transportation to take them to their appointments. In an interview on 9/4/2025 at 12:50pm, the DON stated that on 8/4/2025, Resident #1 came to her to express his frustration that CNA A was suspended and presented the list to her. The DON advised Resident #1 that the information on the list was confidential and asked to take the list from him. He agreed. The DON stated that she expected her staff to follow the facility's protocol to protect residents' confidential information at all times and everywhere. She expected that staff keeps medication carts locked, computers locked and any discussion regarding residents' health information be done in private. CNA A was terminated as a result of her violation. The facility had a third party transportation service to transport residents to appointments in the meantime. In an interview on 9/4/2025 at 1:15pm, the Administrator stated that he expected his staff to respect resident right to their confidential information because violating their rights may result in frauds, emotional and psychological damage. Record review of CNA A's General Employee Orientation Training Inventory, dated 12/1/2020, revealed confidentiality of resident information (HIPAA) was included in the orientation checklist. Record review of CNA A's Privacy acknowledgement and non-disclosure agreement, employee scope of access to Resident Personal Health Information, signed and dated by CNA A on 12/2/2020, revealed that the employee agreed that he or she will not verbally or in any written form disclose confidential resident information to any unauthorized party. Record review of facility's Resident Rights policy, date unknown, revealed The resident has a right to personal privacy and confidentiality of his or her personal and medical records. 1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.</p>		