

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: 455903	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a Registered Nurse was on duty in the facility for a minimum of eight consecutive hours a day, seven days a week, for 6 of 26 weekend days (11/01/2025, 11/02/2025, 11/15/2025, 11/16/2025, 11/29/2025, 11/30/2025) reviewed for RN coverage. The facility failed to have RN coverage on the following dates in 2025:- 11/01/2025, 11/02/2025, 11/15/2025, 11/16/2025, 11/29/2025, 11/30/2025 This failure could place residents at risk of not having their nursing and medical needs met, and other direct care staff not receiving sufficient oversight. Findings included: Review of an undated excel file, covering the RN time stamp hours for weekend dates of the first fiscal quarter of 2026 reflected insufficient RN coverage on the following dates of 2025. - 11/01/2025, 11/02/2025, 11/15/2025, 11/16/2025, 11/29/2025, 11/30/2025 During an interview on 1/08/2026 at 2:56 PM, the DON revealed she was responsible for RN weekend schedules. She said RNs were scheduled to work 6:00 PM - 6:00 AM during the weekends and the RNs would take a break from 6:00 AM to 6:00 PM and return for the next 6:00 PM - 6:00 AM shift (providing 6 hours of coverage in the morning and 6 hours of coverage in the evening). The DON had thought the facility just needed at least 8 hours of coverage during weekend days, not 8 consecutive hours. During an interview on 1/08/2026 at 3:20 PM with the ADM revealed he understood the RN weekend day scheduled as RNs were scheduled from 6:00 AM - 6:00 PM, because that was the schedule for weekdays. He stated the risk of not having an RN in the facility for 8 consecutive hours was not having staff present with the clinical expertise of an RNs and knowledge to make decisions for (a resident's) life. The facility did not have a policy regarding nurse staffing.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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. Based on observation, interview and record review, the facility failed to provide safe and secured storage of drugs and biologicals by not keeping medication in locked compartments, for 1 of 5 carts reviewed for medication storage in that:LVN A failed to lock treatment cart while not in use. This failure could result in physical injuries to residents; drug diversions, ingestion of medications causing adverse effects and violation of HIPAA (Health Insurance Portability and Accountability Act). Findings includedIn an observation on 1/6/2026 at 9:10am, treatment cart in hall 400 was unlocked when not in use. Inside treatment cart was Resident #1's silver sulfa cream, wound supplies, 2 pairs of scissors, and 2 bottles of wound cleaning liquid. Treatment cart was unlocked and not in use for 5 minutes.In an interview on 1/6/2026 at 9:15am with treatment nurse. She stated medication cart and treatment cart should be locked at all times due to risk of injuries to residents and HIPAA violation. She stated a resident could have gotten ahold of wound cleaning liquid and caused chemical injuries. She also stated a resident could have sustained physical injuries using the scissors in an unlocked cart. She stated she forgot to lock the wound cart when she walked back to medication room to get wound supplies to refill the cart. In an interview on 1/8/2026 at 2:30pm, the DON stated that all carts should be locked at all times when not in use. She stated residents could have access to medications or biologicals or medical tools in the carts that could cause harm. The DON also stated that nurses were to lock all carts even if they were going to step away for a brief moment. She stated all nurses were trained to lock all carts when carts are not in use. Review of facility's policy, Medication Administration Procedures, dated 10/25/2027, stated .the medication cart must be completely locked, or otherwise secured.		