STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105382	A. Building B. Wing	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandgate Gardens Rehab and Nursing Center	703 S 29th St Fort Pierce, FL 34947

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews, the facility failed to provide adequate supervision and assistive equipment to prevent 1 of 3 sampled residents, Resident #1, from having a fall with injury.The findings included:Record review revealed Resident #1 was admitted to the facility on [DATE]. Review of a quarterly assessment dated [DATE] documented a Brief Interview Mental Status (BIMS) score of 00 on a 0-15 scale, indicating unable to assess. Review of the medical diagnosis for Resident #1 documented a history of hemiplegia (paralyzed on one side) affecting the dominant side on the right, traumatic brain injury, aphasia (difficulty expressing words), and history of falls. Review of a report dated 10/22/25 documented Resident#1 was found on the floor lying on her left side after reportedly rolling off the bed while being assisted by one staff for incontinent care. The resident was assessed, and a small amount of bleeding was noted from the resident's mouth. There was no documentation related to staff involved in the incident. There was a documented intervention for the fall, that stated the resident will now be required to have the assistance of 2 people for bedside incontinent care.Review of the care plan dated 09/15/25 documented a focus that Resident #1 was at risk for falls related to cognitive deficit and poor balance with a goal of the resident's potential for sustaining a fall-related injury will be minimized by utilizing fall precautions and interventions. A second focus documented Resident #1 had a ADL (activities of daily living) self-care deficit related to chronic medical conditions with a goal that the resident will not have a decline in ADL functioning with the following interventions: for bed mobility the Resident #1 needs extensive help to move and reposition in bed, will need one or two person assistance to change position or scoot up in the bed, this may involve some lifting of legs or boosts; for toileting the resident is dependent and is not able to participate in the task at all and will need staff to move, cleanse, and dress him. This may require the dependent assistance of 2 people to be done thoroughly and safely and bilateral bedrails for bed mobility.Review of a physician order dated 06/24/24 instructed staff to check bilateral bedrails for functionality and safety every night shift.Review of the October 2025 Treatment Administration Record for Resident #1 revealed staff signed indicating that bilateral bedrails for bed mobility was checked for functionality and safety.During an interview on 11/03/25 at 12:18 PM, the Administrator asked if there were any other documents needed. She was made aware that documentation of a thorough investigation including the witness statements for the fall incident for Resident #1 on 10/22/25 was needed for review.During an interview on 11/03/25 at 12:40 PM, the Administrator provided a printed out copy of a progress note documented by the nurse regarding the fall incident on 10/22/25. She was made aware that there was no documentation that indicated the staff involved or witness statement from the staff involved. On 11/03/25 at 1:41 PM, the Administrator provided a copy of a witness statement and stated, Do you want to talk to the CNA involved in the incident? We called her in. During an interview on 11/03/25 at 1:42 PM, when Staff A, the Certified Nursing Assistant (CNA) providing care to Resident #1 on 10/22/25, was asked when the resident fell out of the bed, Staff A stated, Yes, I was changing her brief, I turned her on her right side and she rolled off of the right side of the bed. I was on the left side. When asked were the side rails up, she stated, She doesn't have side rails. When asked if she was the only one assisting the resident at the time of the fall, she stated, Yes, after the resident fell I went to the door and called the nurse. Me and two nurses assisted her back in bed. The nurse said that the resident was on hospice she needed to call them and then do a follow up and send her out to the hospital. When asked when the incident happen, she stated, Early in the morning. I was getting ready to go off shift. I work the 11AM to 7AM shift. When asked if she noticed if the resident had any injuries, she stated, No, nothing new. She had injuries from the previous fall, the forehead on the right side was swollen and her right eye was purple. When asked how Resident #1 is normally when providing care, Staff A stated, She is normally calm. During an observation on 11/03/25 at 1:50 PM, Resident #1's bed was not observed with bilateral side rails. During an interview on 11/03/25 at 2:00 PM, the DON and Administrator were made aware of the interventions that were not followed relating to the resident's fall on 10/22/25, to provide 2-people to assist with incontinent which was already care planned as an intervention since 2024; and that the resident had a physician's order for bilateral side rails which the resident didn't have at the time of the fall. The DON responded, She does? I do realize that there is an issue with doing a thorough investigation.