STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105911	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate Health and Rehabilitation Center	2300 Village Blvd West Palm Beach, FL 33409

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** 22517 Based on observation, clinical and administrative record review, and interview, the facility staff failed to ensure that 2 of 3 sampled residents, Resident # 1 and #2, received the necessary care and services as related to the resident's gastrostomy tube and site and skin assessments, as evidenced by the facility failure to provide evidence that care and services were provided for a resident with a gastrostomy tube, failed to properly assess and provide evidence of care and services for a gastrostomy tube site after removal, and failed to provide evidence that weekly skin assessments were completed for residents. The findings included: Review of the facility's policy and procedure for Administering Medications through an Enteral Tube, revised 01/2024, documented, in part, the following regarding Enteral Tube Care: 1. Cleanse enteral feeding site per the physician orders. Typically, one time per day with normal saline or soap and water. May leave enteral feeding site open to air or cover with a dry dressing as needed. 2. Change enteral feeding syringe per the physician orders. Typically, one time per day. Store in hygienic manner in the resident's room. 3. Check residual per the physician orders. Typically, every shift. Hold medications and enteral feeding if residual is greater than 60 ml and notify the physician. Review of the facility's policy regarding Standards and Guidelines: Prevention of Skin Impairments / Pressure Injury, revised 01/2024, documented, in part: Review the resident's care and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Procedure included for Risk Assessment: 1. Assess the resident on admission for existing wound risk factors. 2. Conduct a comprehensive assessment upon admission including: a. Skin integrity - any evidence of existing or developing pressure ulcers or injuries. b. Areas of impaired circulation due to pressure from positioning or medical devices. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Another gastroenterologist progress note, addendum on 03/04/24 at 6:44 PM, documented the PEG tube was removed per patient and family request. The resident was discharged from the hospital and readmitted to the facility on [DATE]. The admission nursing note on 03/04/24 at 10:19 PM did not provide any assessment or documentation regarding the resident's PEG tube site. The Admission Summary, dated 03/05/24 at 11:31 PM, documented the following: a skin assessment was done, no skin issue noted, the exception of skin tag noted to left upper scapula and peg removal site, dressing is clean and dry, no drainage, no irritation nor swollen noted. Review of the twenty-one physician progress notes from 03/06/24 through 05/31/24 documented the same notation for skin - no rash or lesions abdominal dressing was C/D/I [clean, dry and intact]. Further review of the physician orders did not provide documentation of physician prescriptions prescribing for care, dressing changes and/or treatment to the site of the recently removed PEG tube. An interview was conducted on 08/27/24 at approximately at 3:15 PM with the Licensed Practical Nurse, Staff A. Staff A was the nurse who sent the resident to the hospital on 03/02/24 with nausea and vomiting. She stated when she came on duty, the resident was sitting in a wheelchair, and she noticed she had vomited and had the green bile on her clothing. She had assessed the resident and did not hear any bowel sounds. She called the physician, and he said to send the resident out to the hospital and then she called the resident's daughter, who requested to send the resident to a specific hospital. The surveyor asked Staff A regarding the care and services for the PEG tube. She stated the resident ate by mouth and medications (meds) were by the PEG tube. She stated the PEG tube dressing would have been done on the night shifts. She confirmed she did not see a physician order for the care and services for the PEG tube. The surveyor asked about what the PEG tube site looked like post hospitalization . She stated she doesn't specifically remember but confirmed the assessment did not provide a thorough picture of the site and did not verify whether the site was open or closed. She stated if the site was opened, it would usually close within 2 weeks. The surveyor explained that the documentation was misleading because the initial nursing note documented the dressing was clean and dry. The nurses were not completing the weekly skin checks; and the skin checks completed did not provide information on the PEG tube site. Review of the Nurse Practitioner's notes were the same and were documenting there was an abdominal dressing that was clean and dry for over 2 and 1/2 months after the resident returned to the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 08/27/24 beginning at approximately 3:45 PM with the Advance Registered Nurse Practitioner (ARNP) who stated she normally would check the G-tube dressings to ensure staff are performing the dressing changes. She stated she would prescribe the care and services of dressing changes, flushes, and to check residual for the G-tubes. She did not know what happened with Resident #1 and there not being orders regarding care and services for the resident during her stay in the facility. The surveyor asked the ARNP about the PEG tube site once it was removed because all her notes were the same and documented that the dressing was C/D/I [Clean, Dry, and Intact]. The surveyor inquired whether the site was open or closed upon admission and thereafter. The ARNP was unable to confirm the appearance of the PEG tube site upon admission and during the resident's 2nd admission to the facility. She again stated that she normally would have lifted the dressing to view the area. She stated that once a PEG tube is removed, the amount of time when the site closes varies but it will usually close within two weeks. She confirmed that the site, if open, would need a daily dressing change and need monitoring for signs of infection, etc. She further stated that she would normally prescribe for daily dressing changes until the area closed. She confirmed that this was not done for Resident #1, and she further confirmed that the skin assessment on progress notes were carried over and not changed. Further review of the clinical record for Resident #1 revealed the staff failed to complete the weekly skin assessments for the resident. Review of the plan of care revealed a concern as, The resident is at risk for skin impairment r/t (related to) diabetes, neuropathy, risk for malnutrition, use of anticoagulant/antiplatelet medications, weakness/decreased mobility, s/p (status post) tracheostomy. The interventions included: .Skin checks weekly and as indicated; Report any s/s of skin breakdown to MD/wound team as indicated. Review of the assessment completed for the resident revealed the facility completed an assessment on admission. There were no further weekly skin assessments until 03/06/24 (3 weeks later, the readmission to the facility after a 4-day hospitalization). The next weekly skin assessment was completed on 04/14/24 (more than 5 weeks later). The next weekly assessment was completed on 05/03/24 (over 2 weeks later). An interview was conducted on 08/27/24 at approximately 3:15 PM with Staff A. She stated that when the admission assessments are completed it is placed in the computer and the computer will generate the task of performing the weekly assessments. She had no explanation why the assessments were not completed. 2. Review of the clinical record for Resident #2 revealed the resident was admitted to the facility on [DATE] with a diagnosis of Osteomyelitis of the Vertebrae, Sacral and Sacrococcygeal region. The admission assessment documented a Stage IV pressure in the sacrum and left upper quadrant PEG tube. The 06/07/24 Wound Evaluation identified a Stage IV sacrum wound measuring 4.2 x 3 x 1.2 cm. Further review of the assessments for the resident revealed a 06/10/24, 06/17/24 and 06/24/24 weekly skin assessments. After the resident was readmitted to the facility on [DATE] after a brief hospitalization , a 07/06/24 weekly skin assessment documented the sacrum wound and noted ongoing treatment to her sacrum and left knee. There was no other acute skin alterations noted. Further review of the clinical record on 08/27/24 failed to provide evidence of additional weekly skin assessments completed for the resident after the date of 07/06/24 (over 7 weeks). (continued on next page)

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