

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105911	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  Westgate Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure appropriate care and services for 2 of 27 sampled residents, as evidenced by the failure to administer medications timely for Residents #27 and #117, both of whom voiced complaints. The findings included: 1. Review of the record revealed Resident #27 was admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 3, on a 0 to 15 scale, indicating the resident was severely cognitively impaired.</p> <p>During a phone interview on 08/05/25 at 5:44 PM, a family member of Resident #27 voiced concerns that the nurses at the facility were not administering medication timely. The family member stated the medications were often administered late, and that at times the morning medications were late and then the evening medication were early.</p> <p>During an interview on 08/07/25 at 10:03 AM, when asked the expectation regarding the administration times for resident medication, Staff D, Licensed Practical Nurse (LPN)/Unit Manager, stated the nurses were to administer medications within an hour before or an hour after the physician ordered time.</p> <p>Review of the Medication Administration Record (MAR) for 07/01/25 through 07/24/25 documented the following occurrences for medications that were not administered as per the physician ordered times for Resident #27.</p> <p>For the 7 AM to 3 PM shift, the following was noted:</p> <ul style="list-style-type: none"> <li>a) On 07/01/25, the 10 AM medications were administered at 11:23 AM.</li> <li>b) On 07/03/25, the 10 AM medications were administered at 11:42 AM.</li> <li>c) On 07/04/25, the 10 AM medications were administered at 11:15 AM.</li> <li>d) On 07/05/25, the 10 AM medications were administered at 12:17 PM.</li> <li>e) On 07/06/25, the 10 AM medications were administered at 11:21 AM.</li> <li>f) On 07/09/25, the 10 AM medications were administered at 11:40 AM.</li> <li>g) On 07/10/25, the 10 AM medications were administered at 11:19 AM.</li> </ul> <p>(continued on next page)</p>

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>h) On 07/11/25, the 10 AM medications were administered at 11:11 AM.</p> <p>i) On 07/13/25, the 10 AM medications were administered at 12:38 PM.</p> <p>j) On 07/15/25, the 10 AM medications were administered at 12:02 PM.</p> <p>k) On 07/17/25, the 10 AM medications were administered at 11:18 AM.</p> <p>l) On 07/22/25, the 10 AM medications were administered at 11:33 AM.</p> <p>m) On 07/24/25, the 10 AM medications were administered at 11:57 AM.</p> <p>n) On 07/25/25, the 10 AM medications were administered at 11:31 AM.</p> <p>For the 3 PM to 11 PM shift, the following was noted:</p> <p>o) On 07/02/25, the 6 PM medications were administered at 7:43 PM.</p> <p>p) On 07/03/25, the 6 PM medications were administered at 7:31 PM.</p> <p>q) On 07/04/25, the 6 PM medications were administered at 8:12 PM.</p> <p>r) On 07/05/25, the 6 PM medications were administered at 7:42 PM.</p> <p>s) On 07/07/25, the 6 PM medications were administered at 8:15 PM.</p> <p>t) On 07/09/25, the 6 PM medications were administered at 7:52 PM.</p> <p>u) On 07/11/25, the 6 PM medications were administered at 7:28 PM.</p> <p>v) On 07/12/25, the 6 PM medications were administered at 8:43 PM.</p> <p>w) On 07/14/25, the 6 PM medications were administered at 7:48 PM.</p> <p>The above represents 23 occurrences of late medication during the 24 day period. The medications were administered up to 1 and 1/2 hours late on the day shift, and up to 1 and 3/4 hours late on the evening shift.</p> <p>2. Record review revealed Resident #117 was admitted to facility on 07/30/25. The comprehensive assessment was still in progress, but there was a documented Brief Interview Mental Status (BIMS) score of 15 on a 0-15 scale, indicating no cognitive impairment. Review of the diagnosis revealed Resident #117 had a medical history of Essential Hypertension (an increase in blood pressure), Pain in left leg, Type 1 Diabetes Mellitus (increased blood sugar), and Gastro-Esophageal Reflux Disease (acid in stomach).</p> <p>An interview was conducted on 08/06/25 at 10:16 AM with the Regional Nurse who was asked where Staff F, Registered Nurse (RN) was, and stated, "She had to leave for an emergency."</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 08/06/25 at 10:28 AM with Resident #117 who stated, "I need my medicine. I haven't had my insulin. I need pain medication. When asked if Staff F, RN, had seen her this morning, she stated, "The nurse came into my room while I was eating breakfast, and she said she would be back with my medications."</p> <p>During a follow up interview on 08/06/25 at 11:10 AM, when asked if she had received her morning medications yet, Resident #117 stated "No, no one has come yet." During an observation on 08/06/25 at 11:10AM while standing in the hallway, Resident #117's room was observed with the call light on.</p> <p>During an observation on 08/06/25 at 11:20AM, Staff G, Certified Nursing Assistant (CNA), was observed coming out of another resident's room, and she saw that Resident #117 light was on, and she went into the resident's room.</p> <p>During an interview on 08/06/25 at 11:21AM, the Director Of Nursing (DON) asked if everything was ok, and at that same time Staff G was walking down the hallway towards the DON. The DON asked what Resident 117 needed. Staff G stated, she needed her pain medication. I haven't been able to find Staff F, RN, "ve been looking for her." The DON stated, she is outside on a phone call.</p> <p>During an interview 08/06/25 at 11:30AM, the Assistant Director Of Nursing (ADON) was noted at the medication cart on the 100-112 unit, who was asked if she was administering medications in place of Staff F, RN. The ADON stated, "Yes, I'm getting medications for another resident, When asked if the medications were being given late, she stated, "I just received an order to administer the medications late." The ADON was made aware of Resident #117 not receiving her morning medication, which included the scheduled insulin. She was told that Resident #117 was requesting pain medication. The ADON stated "I will give her medications next."</p> <p>During an interview on 08/06/25 at 11:48 PM, Resident #117's call light was observed to be on, who when asked if she had received her medications, the resident stated, "No." At that time, the resident was on the phone, and stated, "I've been here 10 days, and I can never reach anyone at the front desk on the phone. I'm having so much pain." The Regional Nurse entered the resident's room and asked, "Is everything ok?" At that time, she was made aware of Resident #117's concern of not receiving her morning medication, had complained of pain and hadn't received pain medication since 6:00 AM on 08/05/25. The Regional Nurse ran down the hallway to get the ADON. They went back to Resident #117 room with the medication cart.</p> <p>During an interview on 08/06/25 at 1:15 PM, when asked if she received her medications, Resident #117 stated, "Yes, finally if it wasn't for you, I would not have received them."</p> <p>Review of the requested time stamped Medication Administration Record (MAR) for Resident #117 revealed the resident received her scheduled 10:00 AM medications between 12:09 PM and 2:19 PM on 08/06/25. The pain medication that was requested was documented as administered at 11:54 AM on 08/06/25. Further review of the time stamped MAR revealed the medications that were scheduled at 8:00 PM on 07/30/25 were documented as administered at 10:15 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/07/25 at 9:10 AM, when asked why residents received medications so late on 08/06/25, the DON stated, "I wasn't aware that Staff F, RN was going to be off the unit for a long period of time. When asked when she knew the nurse would not be returning, the DON, stated "At 11:47 AM, I received a text from her that stated she was on a telephone case, and she couldn't get off the phone." When asked if she was aware that the nurse had not administered medications to all of her assigned residents, the DON stated, "No, not when she left, I thought she was going to be on a thirty-minute call. Staff F, RN came in because the scheduled nurse called off." When asked if Staff F, RN was the Unit Manager (UM), the DON stated, "She resigned from the UM position two weeks ago and she hadn't been working here."</p>		