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	12/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (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 0609 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 administrative and clinical record review and interviews, the facility failed to ensure that all allegations involving abuse, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made, as evidenced by the staff failure to inform the appropriate administrative staff of a reported allegation of abuse in a timely manner affecting 1 of 3 sampled residents reviewed (Resident # 1), who apparently made multiple contacts with staff informing them of the alleged abuse before the facility made an attempt to act upon this allegation days later. The findings included:An interview was conducted on 12/15/25 beginning at approximately 2:30 PM with Resident #1 via a visual sign language interpretation line. Resident # 1 is a deaf mute who was admitted to the facility on [DATE] with diagnoses which included Discitis, Collapsed Vertebra, Radiculopathy, Type 2 Diabetes, Hypertension, Hyperlipidemia, Hypothyroidism, Insomnia, and Unspecified Hearing Loss. The resident's Brief Interview for Mental Status scored 14, which indicate that the resident is cognitively intact and healthy. The resident reported that she was admitted to the facility on [DATE] at night. After she was left at the facility by the paramedics, she stated she was in so much pain and she asked for help, but no one would help her. She stated she asked for pain medications and later 2 nurses came in. She needed to be changed also, but she couldn't open her legs, and the staff began to hit her on her stomach and back (motioning to these areas). She further stated she told the nurse, but nobody helped her. She also said she called 911, and the police came out but they said it was nothing they could do. She expressed that she had surgery in November and she came here and they did all this to me. She further stated some of the nurses are mean, some are good. She was asked if she could describe the nurses. She gave a general description at this time (almost three weeks later) but further stated it was hard for her to remember their faces. She also showed the surveyor some pictures of her abdomen and back that were dated December 3rd. The picture showed her suture sites from her back surgery and multiple dark bruises on her abdomen (it should be noted that the resident does receive anticoagulation drug injections daily). However, it was not totally clear who took the pictures which were on the resident's personal phone.An interview was conducted on 12/15/25 at approximately 3:30 PM with the Unit Manager. She confirmed she was not aware of any allegations of abuse with Resident # 1 until 12/03/25. When she learned of this allegation, she and another nurse performed a skin assessment on the resident on 12/03/25, when the Administrator was informed of the allegation. She stated she documented the skin assessment. The surveyor then showed her pictures of the resident, which were obtained from the resident's phone to confirm the condition of the resident's skin. She stated that the pictures confirmed the majority of what she observed on 12/03/25 except there was an additional bruise on the resident lower abdomen near the right hip area that she did not recall seeing nor did she document this area on the resident's skin assessment. The surveyor then reviewed with the Unit Manager, previous skin assessments on the resident from admission and the second skin check done after admission. She confirmed they did not document the same or similar bruising noted on her 12/03/25 skin assessment. We further reviewed the hospital records to determine if a skin assessment was completed and sent with the resident. The 3008 does not note any concerns regarding the resident's skin. However, it should be noted that the resident was receiving anticoagulation drug injections in the hospital as well.Review of the facility's administrative records did not reveal a report of an allegation of abuse associated with Resident # 1. There was a noted grievance on 12/03/25 regarding communication needs for the resident.Multiple interviews were conducted on 12/15/25 in the morning and afternoon with the Administrator, who reported that she was informed of an occurrence with Resident # 1 on 12/03/25 when the Therapist Assistant reported what the resident told her about being hit by staff. She stated she also called the police and reported the incident to the state agency but withdrew the report when told by her corporate staff that it was a grievance instead because they felt it was a communication issue. She stated when she called the police, she was informed that the police had received multiple calls from the resident and came out to the facility on [DATE] but nothing was done.The administrator provided a handwritten note from the resident, when she inquired about the incident from the resident on 12/03/25. The resident documented, The ambulance took me to the facility Friday night from the hospital. When I arrived there, two nurses and 1 secretary were there. Two nurses looked at me looking mean! They showed their ugly faces to me and then abused my abdomen, thigh and back, then tried to pull my diapers. I cried!!! I tried to call 911 and police. But they said they could not do anything for me. My daughter came here Saturday afternoon, and she and my