| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105911 | A. Building<br>B. Wing | 04/11/2024 |

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| Westgate Health and Rehabilitation Center | 2300 Village Blvd<br>West Palm Beach, FL 33409 |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on observation, interview, and record review, the facility failed to ensure timely smoking privileges as per resident choice and schedule for 2 of 5 sampled residents who smoke, Residents #159 and #259. At the time of the survey, there were five residents residing in the facility who smoked.<br><br>The findings included:<br><br>Upon entrance to the facility, an observation at the first-floor nurses' station revealed a sign that documented, Smoking Times: 10 AM, 2 PM, 4 PM, and 6:30 PM.<br><br>Review of the record revealed Resident #159 was admitted to the facility on [DATE]. Although the Brief Interview for Mental Status (BIMS) score had not yet been completed, review of the progress notes documented the resident was alert and oriented.<br><br>During an interview on 04/09/24 at 9:03 AM, Resident #159 stated there were different Certified Nursing Assistants (CNAs) assigned to the smoking area at different times throughout the day, and they were never on time.<br><br>During an observation at the first-floor nurses' station on 04/09/24 at 10:05 AM, the Director of Nursing (DON) and Unit Manager were unable to find Staff C, CNA, who was assigned to the smoking area, as documented on the staff assignment written on the white board. The DON asked the Unit Manager to cover the smoking area, STAT (immediately) as it's 5 after [the scheduled time]. The Unit Manager walked down the hall looking for Staff C and was unable to find her. The Unit Manager then went to get the smoking box (a small container that held the resident's cigarettes and lighters), and went out to the smoking area at 10:06 AM. Residents #159 and #259 were waiting outside. A third resident arrived at 10:11 AM. Staff C, CNA, arrived to the area on 04/09/24 at 10:12 AM.<br><br>(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 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation of the smoking area on 04/10/24 at 4:06 PM revealed Resident #159 in the smoking area with Resident #259. Staff D, CNA, was attending to the two residents. When asked how the smoking area staff were scheduled, Staff D explained for the 3 PM to 11 PM shift, the first floor staff was responsible for the 4 PM smoking time and the second floor staff was responsible for the 6:30 PM time. Resident #159 stated Staff D was always on time, but was the only CNA who was timely. Staff D stated, It's the last smoke time that is the problem and pointed up to the second floor. Staff D stated it could be as late as 7:30 or 8 PM before the second-floor staff come down. Resident #159 agreed it could be as late as 7:30 or 8 PM before the second-floor staff come down. Staff D stated, Sometimes I just come out to give them their smoke break. They (the residents) deserve it. It's their right.<br><br>On 04/11/24 at 10:01 AM, the smoking area was being attended to by the Unit Manager with four residents who smoke, even though it was assigned to a CNA.<br><br>During an interview on 04/11/24 at 11:17 AM, when asked about the timeliness of staff for the smoking area, Resident #259 stated the day shift was ok, but staff for the last one (scheduled for 6:30 PM) were usually 30 minutes or more late. Resident #259 had a Brief Interview for Mental Stats (BIMS) score of 13, on a 0 to 15 scale, indicating the resident was cognitively intact.<br><br>During an interview on 04/11/24 at 2:45 PM, when asked how the smoking area staff were assigned, the Assistant Director of Nursing (ADON) explained the first floor was responsible for the 10 AM and 4 PM times, and the second floor for the 2 PM and 6:30 PM times. The ADON stated they all get busy, so they all pitch in and help each other out. When told there were voiced concerns about the 6:30 PM staff being 30 to 60 minutes late, the ADON stated maybe 10 or 15 minutes, but she doubted it was more than that as she was often at the facility during that time. The ADON stated, they call me the Smoking Police as I know how important it is for the residents. The ADON stated she was not there on the weekends. When told there were complaints from 2 smokers and one staff, the ADON stated, Oh. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on observation, record review and interview, the facility failed to ensure accurate Minimum Data Set (MDS) assessments for 3 of 34 sampled residents, related to the Brief Interview for Mental Status (BIMS) score for Resident #43, antibiotic use for Resident #3, and discharge location for Resident #108.<br><br>The findings included:<br><br>1. Review of the record revealed Resident #43 was admitted to the facility on [DATE]. Review of the Annual MDS assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 6. The BIMS score is determined in part by asking the resident to repeat a pattern of words.<br><br>During observations and attempted interviews on 04/08/24 at 11:06 AM and on 04/09/24 at 9:24 AM, Resident #43 did not verbally respond.<br><br>During an interview in the morning of 04/08/24, Staff K, Certified Nursing Assistant (CNA), confirmed Resident #43 could not speak or move, but would only blink her eyes for yes and no questions.<br><br>During an interview on 04/11/24 at 11:32 AM, when asked about conducting an interview for BIMS status, the Social Services Director (SSD) confirmed the resident would need to be verbal or able to utilize cue cards developed for assessing the BIMS status. When asked specifically about Resident #43 and the documented BIMS score of 6, the SSD confirmed that was an error.<br><br>2. Review of the record revealed Resident #3 was admitted to the facility on [DATE]. Review of the Quarterly MDS assessment dated [DATE] documented the resident was receiving an antibiotic. Review of the corresponding orders and Medication Administration Record (MAR) lacked any documented antibiotic use.<br><br>During an interview on 04/11/24 at 11:42 AM, the MDS Director agreed with the error.<br><br>39142<br><br>3. Review of the closed record for Resident #108 for hospitalization revealed in the progress notes that Resident #108 was discharged home and not transferred to the hospital. The two general notes found were dated 1/27/24 at 13:55 (1:55 PM) and 13:59 (1:59 PM). The 13:55 note text was as follows: Patient discharge summary reviewed copy given to patient. Patient education provided for diabetic teaching and oxygen. Patient given all medications reviewed. Patient safety and comfort maintained. The 13:59 note text was as follows: patient exiting with all belongings at this time.<br><br>Review of the record for Resident #108 documented there were two discharge orders identified for Resident #108.<br><br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The first discharge order was written on 01/26/24 at 10:02 AM and was written as follows: Discharge Home on 1/26/2024 with Home Health-RN/PT/OT eval. treat. Home Health Aide for ADLs. DME to include O2 concentrator and portable tank for O2, 2L via nasal canula and acc check machine for blood sugar monitoring.<br><br>The second discharge order was written on 01/26/24 at 21:13 [9:13 PM] and was written as follows: [Resident] Home with family. Family/Son will pick-up at 11am. Patient already has new portable oxygen tank to go home with in her room. (Please be sure patient is ready).<br><br>On 04/11/24 at 4:04 PM, an interview was conducted with Staff E, the MDS Coordinator with the MD Director present. Staff E reviewed Resident #108's records and he verified the findings of the surveyor. Staff E located a discharge assessment, with the date of 01/26/24, that indicated the discharge was to the resident's home. Staff E admitted to his error and surmised he accidentally selected the wrong entry on the MDS Discharge assessment. Staff E explained the most likely reason for the incorrect discharge on the MDS was because of a miss-click of the mouse. When Staff E was asked how he could miss-click on option 4 instead of option 1, he stated he could have been scrolling quickly and accidentally clicked on hospitalization , option 4, instead of home, option 1. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on record review, observation, and interview, the facility failed to provide the appropriate treatment and services related to a clinically justified indwelling urinary catheter for 1 of 6 sampled residents, Resident #42.<br><br>The findings included:<br><br>Review of the record revealed Resident #42 was admitted to the facility on [DATE] with a diagnosis of chronic kidney disease. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident was severely cognitively impaired and had memory problems. This MDS also documented Resident #42 had an indwelling urinary catheter and was totally dependent upon staff for all care.<br><br>Further review of the record revealed orders dated 03/01/24 for staff to provide indwelling catheter care every shift as needed, and to irrigate the catheter using 60 ml (milliliters) of normal saline every eight hours as needed for blockage, leakage, increased sediment, or decreased output.<br><br>An additional order dated 03/02/24 had instructions to change and date the catheter securement (anchoring) device every week.<br><br>Review of the April 2024 Treatment Administration Record (TAR) documented the indwelling urinary catheter had been changed on 04/06/24.<br><br>An observation on 04/08/24 at 9:00 AM revealed Resident #42 lying in bed. An indwelling urinary catheter bag was noted hanging from the resident's bed. The urine in the tubing was red tinged. A yellow paper tag attached to the indwelling catheter tubing was dated 03/31/24. Photographic Evidence Obtained.<br><br>During an observation on 04/09/24 at 3:19 PM, Staff J, Certified Nursing Assistant (CNA), uncovered Resident #42. The red tinged urinary catheter tubing was freely hanging in between the resident's thighs, without any type of an anchoring device.<br><br>During an observation on 04/11/24 at 9:04 AM, Staff A, CNA, confirmed she provided the morning care for Resident #42 earlier that day. An observation of the resident's thighs lacked any type of anchoring device. When asked about the use of an anchor for the indwelling urinary catheter tubing, Staff A confirmed they were used at the facility, and agreed there should be one in use for Resident #42. Observation of the tubing revealed the urine was now clear.<br><br>During an interview and side-by-side review of the April 2024 TAR on 04/11/24 at 9:59 AM, the Unit Manager agreed the TAR documented the indwelling urinary catheter was changed on 04/06/24, yet the date on the observed catheter was 03/31/24. The Unit Manager was shown the photograph of the red tinged urinary catheter tubing from 04/08/24 and agreed the catheter should have been irrigated or changed as of the 04/09/24 observation in the afternoon. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167<br><br>Based on observation, interview and record review, the facility failed to ensure an intravenous peripherally inserted central catheter (PICC) line dressing was changed as ordered for 1 of 1 sampled resident, Resident #362.<br><br>The findings included:<br><br>Record review revealed that Resident #362 was admitted to the facility on [DATE], with diagnosis that included Septicemia (blood poisoning by bacteria). The admission Minimum Data Set (MDS) assessment, reference date 03/29/24 (which was completed and ready to export), recorded a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #362 was cognitively intact. This MDS recorded no mood or behavior issue.<br><br>Subsequent review of the clinical record evidenced a physician order dated 03/24/24 of Ceftolozane-Tazobactam (an antibiotic) Intravenous Solution Reconstituted 1.5 (1-0.5) GM to use 1.5 gram intravenously every 8 hours for wound infection until 04/22/2024. An additional physician order dated 03/24/24 documented for the PICC line dressing to be changed every 7 day(s). A subsequent order dated 03/25/24 documented for the 'PICC Line left arm, change dressing within 24 hours of admission, insertion, or reinsertion and every 7 days and as needed thereafter using sterile technique. Measure arm circumference and external length of catheter.'<br><br>Review of the March 2024 and April 2024 medication administration records (MARs) and treatment administration records (TARs) indicated the PICC line dressing had been changed on 03/24/24, 03/26/24, 04/02/24, and 04/07/24.<br><br>On 04/08/24 at 11:59 AM, an observation was made of Resident#362, who was verbally responsive, alert, oriented, and calm, with no behaviors noted. During the observation, the resident's intravenous (IV) site dressing to the left upper arm was observed and had a date of 3/23. Resident #362 confirmed the IV had been inserted since being at the hospital. When asked whether the IV dressing was changed by the facility staff, Resident #362 stated no.<br><br>On 04/11/24 at 11:01 AM, an interview was held with the Director Of Nursing (DON), who was made aware of the finding and concern related to the IV dressing not being changed as ordered and that staff had documented the IV dressing was changed only on four occasions. A side-by-side review of Resident #362's record was conducted with the DON, who acknowledged the finding. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on observation, interview, record review, and policy review, the facility failed to ensure care and services for oxygen use for 2 of 3 sampled residents, Residents #59 and #55.<br><br>The findings included:<br><br>Review of the policy, titled, Oxygen Administration, revised 12/2023, documented, in part, General Guidelines: . 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or other device per physicians' orders and/or facility protocol. 4. Store oxygen tubing in a hygienic manner (i.e. labeling bag with date tubing was changed).<br><br>1. Review of the record revealed Resident #59 was admitted to the facility on [DATE], and moved to her current room on 04/15/23. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented oxygen was in use. Review of the vital sign record revealed oxygen saturations on 04/08/24 and on 04/09/24 were taken those mornings while the resident was on oxygen.<br><br>Review of the record revealed an order dated 10/15/23 for the use of continuous oxygen at 2 liters per minute via nasal cannula for shortness of breath. Review of the care plan revised on 10/17/23 documented Resident #59 was at risk for altered respiratory status / difficulty breathing related to shortness of breath. The interventions included administering the oxygen as ordered.<br><br>An observation on 04/08/24 at 11:37 AM, revealed Resident #59 in bed, wearing the nasal cannula, and the oxygen concentrator running at 2 liters per minute. Further observation revealed the oxygen tubing, dated with a piece of tape labeled 4/7/24, was not attached to the concentrator. Photographic Evidence Obtained. Resident #59 denied shortness of breath at that time.<br><br>An observation on 04/09/24 at 11:25 AM revealed Resident #59 in bed. The oxygen concentrator was running at 2 liters, but the same oxygen tubing as observed the previous day, was lying on the bed and not hooked to the concentrator. Photographic Evidence Obtained.<br><br>On 04/10/24 at 9:39 AM, Resident #59 put on the call light. A random staff member entered the room, and the resident requested that her head of the bed be adjusted. The staff assisted the resident and left the room. Upon entering the room after the staff left, the oxygen concentrator was running. The same tubing dated 04/07/24 was lying over the concentrator, with the nasal cannula on the floor, and was not hooked to the concentrator. Photographic Evidence Obtained.<br><br>On 04/10/24 at 2:40 PM, the same oxygen tubing that had been observed throughout the survey, not attached to the oxygen concentrator and/or on the floor, was now in the resident's nose, but still not hooked to the concentrator. Staff B, Licensed Practical Nurse (LPN), and Staff F, Certified Nursing Assistant (CNA), both direct caregivers for Resident #59, denied picking up the oxygen tubing from the floor and putting it on Resident #59. Staff F, CNA, stated she found the tubing on the bed and put it on the resident.<br><br>2. Review of the record revealed Resident #55 was admitted to the facility on [DATE]. Review of the current MDS assessment dated [DATE] documented the use of oxygen by the resident.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Further review of the record revealed the following three orders related to the use of a nebulizer (machine used for the administration of a medication by inhalation):<br><br>An order dated 06/11/23 documented staff were to change the nebulizer treatment tubing weekly and place the mask in a bag.<br><br>An order dated 11/07/23 documented Ipratropium-Albuterol Solution, a respiratory medication, was administered every four hours for COPD (Chronic Obstructive Pulmonary Disease, a lung and breathing disorder).<br><br>An order dated 12/15/23 documented Yupelri Solution, a respiratory medication, was to be given daily at bedtime.<br><br>An observation on 04/08/24 at 12:35 PM revealed the nebulizer mask, used to administer the respiratory medication, was lying on top of the nebulizer machine, and the plastic storage bag was noted to the left of the machine on the bedside nightstand. Further observation of the machine revealed the machine was dirty with debris in the cavity of the machine. Photographic Evidence Obtained.<br><br>An observation on 04/09/24 at 11:23 AM revealed the nebulizer mask was lying on top of the nightstand, but again not in the storage bag.<br><br>An observation on 04/10/24 at 10:22 AM revealed the same nebulizer and improper storage method of the mask.<br><br>During an interview on 04/11/24 at 9:57 AM, Staff B, LPN, agreed the nebulizer machine needed to be either cleaned or replaced, and the tubing replaced and stored properly. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50370<br><br>Based on record review, observation, and interview, the facility failed to implement physician ordered blood pressure monitoring parameters for 1 of 6 sampled residents, Resident #78, as evidenced by lack of BP documentation and to ensure adequate monitoring.<br><br>The findings included:<br><br>Review of the record revealed Resident #78 was admitted to the facility on [DATE], with a diagnosis that included Essential Primary Hypertension (high blood pressure). Further review of the record revealed an order dated 09/26/23 to give Lisinopril 20 mg (milligrams) by mouth one time a day for Hypertension. The order also included a monitoring parameter to hold the medication for a systolic blood pressure (SBP) reading of less than 130.<br><br>Review of the January 2024, February 2024, March 2024, and the current April 2024 Medication Administration Record (MAR) revealed Resident #78's blood pressure results were not documented. Review of the vital signs section of the electronic record revealed the following:<br><br>a. Blood pressure (BP) results were documented on 01/13/24, 01/16/24, 01/21/24, 01/22,24 and 01/23/24, which was only 5 of the 31 days in January 2024.<br><br>b. BP results were documented on 02/04/24 and 02/17/24, which were only 2 days in February 2024.<br><br>c. BP results were documented on 03/04/24 and 03/23/24, which were only 2 days in March 2024.<br><br>d. There were no documented BP results for the month of April 2024, until after surveyor intervention on 04/10/24.<br><br>Additional review revealed that on 12/11/23, and 12/18/23, Lisinopril BP medications were given even when the documented systolic BP were below 130.<br><br>During an interview on 04/10/24 at 11:15 AM, the Unit Manager stated the APRN (Advanced Practice Registered Nurse) wrote the order and that she herself confirmed it. The Unit Manager confirmed the BP should be recorded on the MAR, when physician ordered parameters are in place. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404<br><br>Based on observation, interview, record review, and policy review, the facility failed to ensure proper disinfecting of glucometers (devices to obtain a blood sugar level) for 2 of 3 sampled residents observed (Residents #23 and #19); failed to properly disposing of a used lancet for 1 of 3 sampled residents (Resident #71); failed to ensure proper hand hygiene during the passing of meal trays for 1 of 2 floors (second floor); failed to implement enhanced barrier precautions (EBPs) for 2 of 11 sampled residents (Residents #18 and #359); and failed to ensure personal protective equipment (PPE), for use for with enhanced barrier precautions, was readily accessible for use with residents on 2 of 2 floors (first and second floor). At the time of the survey, there were 16 residents' rooms identified as needing PPE, to include gowns, for proper implementation of EBPs. The census at the time of survey was 110.<br><br>The findings included:<br><br>Review of the policy, titled, Blood Sampling - Capillary (Finger Sticks), revised September 2014, documented, in part, Steps in the Procedure: . 7. Discard lancet and platform into the sharps container. 8. following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use.<br><br>Review of the User's Guide for the EvenCare Blood Glucose Monitoring System, the glucometer used at the facility, documented, in part, The EvenCare G3 Meter should be cleaned and disinfected between each patient. To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use. Wipe all external areas of the meter including both front and back surfaces until visibly wet. Avoid wetting the meter test strip port.<br><br>The following products have been approved for cleaning and disinfectin the EvenCare G3 Meter: Dispatch Hospital Clean Disinfectant Towels with Bleach, Medline Micro-Kill Disinfecting, deordorizing Cleaning WIpes with Alcohol, Clorox Healthcare Bleach Germicidal and Disinfectant Wipes and Medline Micro-Kill Bleach Germicidal Bleach Wipes .<br><br>Review of the Sani-Cloth Germicidal Disposable Wipe instructions documented, in part, To disinfect and deodorize hard, nonporous surfaces: . Unfold a clean wipe and thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Let air dry.<br><br>1. A medication observation pass for Resident #23, was made on 04/09/24 beginning at 3:49 PM, with Staff G, Licensed Practical Nurse (LPN). The LPN took the supplies into the resident's room, preformed the finger stick to obtain the blood for the blood sugar level, and returned to the medication cart. The LPN wiped the glucometer with an alcohol pad and set it on the top of the medication cart. At 4:09 PM, the LPN placed the glucometer into the medication cart, without disinfecting it with an approved product.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105911 | A. Building<br>B. Wing | 04/11/2024 |

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

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 04/09/24 at 4:40 PM, when asked how to disinfect a glucometer, Staff G, LPN stated, I either use the purple top (disinfectant) or an alcohol wipe. When asked why she did not use the purple top disinfectant, the LPN stated, Because I didn't have any on the cart. The LPN explained there was usually a container of disinfectant wipes on the side of the medication cart.<br><br>An observation at that time revealed no container of disinfectant wipes on the medication cart. When asked if she had the individual Clorox Bleach Germicidal wipe, as that was used by another staff member, the LPN stated she had seen them before but didn't have any.<br><br>During an interview on 04/09/24 at 4:51 PM, the Director of Nursing (DON) agreed with the improper glucometer disinfecting.<br><br>2. During the continued medication observation pass on 04/09/24 at 4:10 PM, Staff H, LPN, obtained supplies to do a finger stick for Resident #19. After completing the process of using the glucometer to test for blood sugar level, the LPN returned to the medication cart and wiped the glucometer with a disinfectant wipe, and then immediately wrapped it in a dry tissue. The LPN failed to ensure a proper wet time, as per the disinfectant instructions.<br><br>During an interview on 04/09/24 at 4:51 PM, the Director of Nursing (DON) agreed with the improper glucometer disinfecting.<br><br>3. A medication observation pass for Resident #71 was made on 04/09/24 beginning at 4:21 PM with Staff I, Registered Nurse (RN). The RN gathered supplies to complete a finger stick, and upon completion, threw the used lancet into the resident's trash can in the resident's bathroom.<br><br>During an interview on 04/09/24 at 4:51 PM, the Director of Nursing (DON) agreed with the improper disposal of the lancet.<br><br>4. The facility did not have a policy for Enhanced Barrier Precautions (EBP), but verbalized they were following CDC (Center's for Disease Control and Prevention) guidance. Review of current CDC guidance revealed the use of gowns and gloves were to be used by staff providing high-contact resident care activites, for residents designated as needing EBPs.<br><br>CDC guidance for EBP also included the posting of signage that clearly indicated the high-contact resident care activities that require the use of gown and gloves. The CDC guidance also included the availability of PPE (Personal Protective Equipment) supplies, including glowns and gloves, be available immediately outside of the resident room.<br><br>At the time of the survey, there were a total of 25 residents identified as needing the enhanced barrier precautions.<br><br>Observations during the initial pool process on 04/08/24, identified numerous rooms with a sign on the door that documented, Enhanced Barrier Precautions. The signs lacked any indication of when or how to implement the precautions. During the room by room observations on 04/08/24, it was noted there were no gowns readily accessible in rooms, storage containers, or linen carts, for staff use.<br><br>(continued on next page) |

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| Westgate Health and Rehabilitation Center | 2300 Village Blvd<br>West Palm Beach, FL 33409 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An observational tour of the first floor, on 04/10/24 at 1:13 PM, to ensure accessible PPE (specifically gowns, as gloves were in each room) for resident's on EBPs, including an observation of all linen carts, revealed the following (Photographic Evidence Obtained):<br><br>a) Rooms 100 to 107 had three rooms identified as needing PPE for EBP. One room had a plastic, rollable drawer set with PPE in the room. The other two rooms, located at the other end of the hall, had no gowns readily accessible. The clean linen cart located part way down the hall lacked any gowns for PPE use.<br><br>b) Rooms 108 - 115 had five rooms identified as needing PPE for EBP. None of the rooms had any gowns for PPE use. The linen cart had one package of gowns available.<br><br>c) Rooms 116 to 130 had two rooms identified as needing PPE for EBP. None of the rooms had any gowns for PPE use. One linen cart had one package of gowns under a stack of linens, and the second cart had none.<br><br>39167<br><br>5. On 04/08/24 at 12:21 PM, dining observation was conducted at the upper 200s unit. Lunch trays were being passed by CNAs and the followings were observed: at 12:21 PM: Staff L brought the food tray in room [ROOM NUMBER], Staff L touched items in the room, exited the room, did not conduct hand hygiene, then Staff L removed another tray from the food cart, went in room [ROOM NUMBER]A (a transmission base precaution room) and provided the tray to the resident. At 12:24 PM, Staff L exited room [ROOM NUMBER]A, without conducting hand hygiene, removed another tray from the food cart and provided it to the resident in room [ROOM NUMBER]B.<br><br>6. Clinical record review revealed Resident #18 was admitted to the facility on [DATE], with diagnosis included: MDROS (Multidrug-Drug Resistant Organisms), a condition in which bacteria have become resistant to certain antibiotics. The admission Minimum Data Set (MDS) assessment, reference date 02/23/24, recorded a Brief Interview for Mental Status (BIMS) score of 15, indicated Resident #18 was cognitively intact. This MDS recorded no mood or behavior issue.<br><br>Review of physician order, dated 02/20/24, documented an order for Cefazolin Sodium (antibiotic) Intravenous Solution Reconstituted 2 GM, every 8 hours for Extended Spectrum Beta Lactamase (ESBL). ESBL is an enzyme or chemical produced by germs like certain bacteria, and ESBL enzymes make some antibiotics ineffective. Further review of clinical records revealed a physician order dated 02/20/24 for a Midline [a peripheral inserted central catheter] to the right arm.<br><br>Additional physician orders, dated 04/01/24, documented for Cefazolin Sodium Intravenous Solution Reconstituted 2 GM, every 8 hours for ESBL until 04/06/24.<br><br>Review of current and discontinued physician orders, care plans, and progress notes from February through April 2024 lacked documented evidence of transmission-based precaution being in place.<br><br>On 04/08/24 at 10:58 AM, an observation was conducted of Resident #18, and there was an IV (intravenous) pole in the room, with an empty bag of antibiotic (Cefazolin 2gGM for ESBL) hanging on the pole. There was an IV site obseved to be located to Resident #18's right upper arm, and the dressing was falling apart. There was no transmission base precaution or EBPs noted in place.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 04/08/24 at 11:10 AM, Resident #18 was observed in the process of receiving incontinent care. The staff member was observed in the room changing the resident's incontninent adult brief. The staff member was not wearing a gown.<br><br>On 04/09/24 at 12:35 PM, the resident was observed lying in bed, and the IV was located to the residnet's right arm. There were no transmission base precautions or EBPs noted in place.<br><br>On 04/10/24 at 11:57 AM, a subsequent observation was conducted on Resident #18. The IV was noted to her right arm, and there was no dressing on the IV site. There were no transmission base precautions or EBPs in place.<br><br>7. Resident #359 was admitted to the facility on [DATE], with diagnosis that included: Septicemia (blood poisoning by bacteria). Review of Physician order, dated 04/03/24, documented an order for Cefazolin Sodium Injection Solution Reconstituted 2 GM, three times a day for sepsis until 04/29/24. Review of current and discontinued orders, care plans and progress notes revealed no documented evidence of transmission base precautions or EBPs in place.<br><br>On 04/08/24 at 1:25 PM, an observation and interview were conducted with Resident #359, who revealed that she had an order in place to receive IV antibiotic therapy. During this time, an observation was conducted of the IV site to the right upper arm. There were no transmission base precautions or EBPs in place.<br><br>On 04/09/24 at 12:16 PM, an observation was conducted on Resident #359. There were no transmission base precautions or EBPs in place.<br><br>On 04/10/24 at 11:32 AM, an observation was conducted on Resident #359. There was an IV pole in room with an empty antibiotic bag hanging on the pole. There were no transmission base precautions or EBPs in place.<br><br>On 04/11/24 at 10:49 AM, an interview was conducted with the Director Of Nursing (DON), who was made aware of concerns related to lack of documented evidence of transmission base precautions, EBPs, and lack of hand hygiene by staff during passing of meal trays.<br><br>8. On 4/10/24 at 1:39 PM, six rooms on the second floor were identified for Enhanced Barrier Precaution (EBP). Upon close inspection, it was noted that while gloves were readily available, protective gowns were not observed to be readily available as required. The room numbers identified were #207, #220, #232, #233, #234, and #235. |