

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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)		
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to treat 1 of 1 sampled resident with dignity as evidenced by not providing Resident #37 with a urinal. The findings included: Record review revealed Resident #37 was admitted to the facility on [DATE]. Review of quarterly assessment, dated 05/18/25, documented a Brief Mental Status (BIMS) score of 03 on a 0-15 scale, indicating severe cognitive impairment. During an observation on 08/04/25 at 10:29 AM, the resident was noted to have a medium size clear bowl under his bed with amber colored urine in it. When asked what was in the bowl underneath the bed, the resident stated, Pee. When the resident was asked why he was using a bowl to pee in, the resident stated, That's what I have to pee in. When asked why he was not using a urinal, the resident stated, I don't have one. Photographic Evidence Obtained. During an observation on 08/05/25 at 11:45 AM, Resident #37 was observed lying in his bed. An empty clear bowl, similar to the one observed on 08/04/25, was noted on the nightstand near his bed. There was no urinal was observed in his room. During an interview on 08/06/25 at 6:12PM, when asked if Resident #37 uses a urinal, Staff E, Certified Nursing Assistant (CNA), stated Sometimes, but most of the time he goes in his brief. When asked if she helps him with using the urinal, the CNA stated, Yes. Review of the care plan dated 05/28/25 documented Resident #37 had an ADL (activities of daily living) self-care deficit related to his disease process and chronic medical conditions. An interview was conducted on 08/07/25 at 9:02 AM with the Director of Nursing (DON), the Risk Manager and the Regional Nurse, who were made aware of the bowl of urine observed underneath Resident #37's bed. The DON asked, How did that get there? Why didn't he have a urinal? The DON immediately went to Resident #37's room. The Risk Manager asked, How did that get there, because the resident is not mobile enough to place that under the bed himself? The DON returned to the nurses' station and stated, I gave the resident a urinal.		

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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. 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. 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. 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. For the 7 AM to 3 PM shift, the following was noted: a) On 07/01/25, the 10 AM medications were administered at 11:23 AM. b) On 07/03/25, the 10 AM medications were administered at 11:42 AM. c) On 07/04/25, the 10 AM medications were administered at 11:15 AM. d) On 07/05/25, the 10 AM medications were administered at 12:17 PM. e) On 07/06/25, the 10 AM medications were administered at 11:21 AM. f) On 07/09/25, the 10 AM medications were administered at 11:40 AM. g) On 07/10/25, the 10 AM medications were administered at 11:19 AM. h) On 07/11/25, the 10 AM medications were administered at 11:11 AM. i) On 07/13/25, the 10 AM medications were administered at 12:38 PM. j) On 07/15/25, the 10 AM medications were administered at 12:02 PM. k) On 07/17/25, the 10 AM medications were administered at 11:18 AM. l) On 07/22/25, the 10 AM medications were administered at 11:33 AM. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m) On 07/24/25, the 10 AM medications were administered at 11:57 AM. n) On 07/25/25, the 10 AM medications were administered at 11:31 AM. For the 3 PM to 11 PM shift, the following was noted: o) On 07/02/25, the 6 PM medications were administered at 7:43 PM. p) On 07/03/25, the 6 PM medications were administered at 7:31 PM. q) On 07/04/25, the 6 PM medications were administered at 8:12 PM. r) On 07/05/25, the 6 PM medications were administered at 7:42 PM. s) On 07/07/25, the 6 PM medications were administered at 8:15 PM. t) On 07/09/25, the 6 PM medications were administered at 7:52 PM. u) On 07/11/25, the 6 PM medications were administered at 7:28 PM. v) On 07/12/25, the 6 PM medications were administered at 8:43 PM. w) On 07/14/25, the 6 PM medications were administered at 7:48 PM. 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. 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). 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." 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." 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. During an observation on 08/06/25 at 11:20AM, Staff G, Certified Nursing Assistant (CNA), was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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, I've been looking for her. The DON stated, she is outside on a phone call. 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." 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. 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." 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. 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."		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide treatment to promote wound healing for 1 of 2 sampled residents as evidenced by not changing the dressing as ordered for Resident #11's pressure ulcer. The findings included: Record review revealed Resident #11 was admitted to the facility on [DATE]. Review of the quarterly assessment dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 13, on a 0-15 scale, indicating no cognitive impairment. Review of a wound care note documented by the wound care doctor on 07/30/25, indicated Resident #11 had a non-healed, stage 3 pressure ulcer on her sacrum (bone below the spine above the tailbone) that measured 3cm length x 2.5cm width x 0.6 cm depth. Review of the current care plan dated 07/07/25 documented Resident #11 was at risk for skin breakdown due to weakness and incontinence, with a goal that the resident will have no further skin impairment with an intervention to perform preventative skin treatments as ordered. The care plan documented that the resident was recently treated with intravenous (IV) antibiotic treatment due to ESBL (Extended-Spectrum Beta-Lactamase, contagious bacterial infection) in the urine. Review of a physician order active as of 08/02/25 for Resident #11, instructed the staff to cleanse the sacrum wound with wound cleanser, pat dry, apply skin prep to peri-wound (skin surround wound) then apply Silvadene (cream to prevent infection) and calcium alginate to the wound bed then cover with silicone super absorbent dressing daily and as needed. Review of a physician order written on 08/06/25 at 11:30 AM for Resident #11, instructed staff to cleanse sacrum wound with normal saline (salt solution), apply Silvadene cream to the wound and leave uncovered daily and as needed. During observation of wound care for Resident #11, on 08/06/25 at 12:30 PM, the Wound Care (WC) Nurse was asked if there was a change to the wound care order for the sacrum wound, she stated, Yes, the wound to the sacrum is to be left open to air after applying the Silvadene cream. The Regional Nurse was at bedside to assist with turning the resident while the WC nurse performed the care. When Resident #11 was turned on her left side and the brief was removed, no dressing was covering the sacrum wound. When the WC nurse was asked if she removed a dressing from the wound she stated, No. When asked did you see the resident on 8/5/25 for wound care, the WC nurse stated, Yes, I did. When asked did she apply a dressing to the sacrum wound, she stated, No. The sacrum wound was noted to have an opening approximately the size of a quarter with depth, edges appeared white, eschar (brown tissue) to the wound bed and slight redness was noted to the buttocks area but the skin was intact. When asked do you know why the order was changed, the WC nurse stated, I requested an order from the wound care doctor this morning to leave the sacrum wound uncovered, because I noticed that the buttocks area was red due to moisture and I wanted to try to dry the area out. When asked if the wound care doctor saw Resident #11 today, she stated No. When asked why she didn't wait until after the wound care doctor saw the resident before requesting the order to be changed, the WC nurse stated, I can always call him to come back to see her. The Regional Nurse observed Resident #11's sacrum wound and stated, The wound needs to have a dressing over it. I will call the wound care doctor now to get him to change the order. The Regional Nurse left the room and came back with a verbal order to cleanse the sacrum wound with normal saline, apply Silvadene cream to the wound and pack with calcium alginate, then cover with a foam dressing every other day. During an interview on 08/07/25 at 1:45PM, the WC nurse was asked if she documented the wound care provided to Resident #11 on 08/05/25, she stated, Yes. She was then asked to show documentation of her care on 08/05/25. After looking through the record, the WC nurse was unable to find any documentation. The WC nurse was asked why she didn't perform the ordered wound care for Resident #11 when she saw her on 08/05/25, and she stated I didn't see any wound care orders for the resident in the record.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, observation, record review and interviews, the facility failed to ensure that 2 of 5 sampled residents with indwelling Foley catheters (urinary drainage device) received proper care and assessment as evidenced by failure to assess Resident #117 for removal of the Foley catheter in a timely manner and ensure the Foley catheter was secured with a statlock (device to prevent dislodgement); and failure to assess Resident #123 for removal of the Foley catheter in a timely manner. The findings included:The finding included: Review of the facility policy review, titled, Standards and Guidelines: Catheter Care-quality of Care, revised 01/2004, documented in part: .Standard: The facility will maintain infection guidelines related to catheter use and catheter care to minimize catheter associated infections. Procedure: 5. Changing indwelling catheters or drainage bags routinely and at fixed intervals is not recommended. Rather it is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised at the discretion of the medical provider. 1.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. Further review revealed the resident was admitted to the facility with an indwelling Foley catheter. During an interview on 08/04/25 at 11:42 AM, Resident # 117 stated, I have a Foley, but they don't even empty it or know that I have one. During an interview on 08/05/25 at 10:50 AM, Resident #117 was asked if she had a catheter, and stated, Yes I do, but the staff don't seem to know, because they always pull on it. When asked if she had a device that holds it in place, the resident showed me her left leg and an undated statlock was noted on her left thigh, but the Foley catheter was not secured to the device. During an observation on 08/06/25, Resident #117 was in her bed laying on her right side and a statlock was noted on her left thigh, but the Foley catheter was not secured to it. When asked if the Foley catheter been secured to the device, the resident stated No. Record review revealed an order dated 07/31/25 instructing staff on every shift (7AM-3PM, 3PM-11PM, 11PM-7AM) to use or apply a catheter tube securing device and the device may be replaced and location changed as needed. Review of the time stamped Medication Administration Record (MAR) revealed that the staff acknowledged, by signing on 08/05/25 and 08/06/25 for every shift, the use of or application of the catheter securing device for Resident #117 to secure her foley catheter. Review of the care plan documented Resident #117 was at risk for Urinary tract infection (UTI) related to history of or actual catheter use, incontinence of bowel with a goal that the resident will remain free from signs and symptoms of UTI . Secondly, the care plan documented that the resident was at risk for injury/infection related to the presence of the catheter with a goal that the resident will be free of complications related to catheter use and intervention to review with the doctor appropriateness for removal of the catheter. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the progress notes for Resident #117 did not reveal any documentation by staff indicating the resident was assessed for possible removal of the Foley catheter prior to 08/07/25. 2. Record review revealed Resident #123 was admitted to the facility on [DATE] with a urinary drainage device (urinary catheter). Further review of the record lacked any attempt to discontinue the urinary drainage device. Review of a progress note dated 07/29/25 by Staff B, Nurse Practitioner, documented the plan to remove the urinary drainage device and complete a voiding trial, pending the results of a urinalysis. Review of the urinalysis completed on 07/29/25 revealed the result was reported to the facility as negative, meaning no Urinary Tract Infection (UTI), on 07/30/25. The urinary drainage device was not discontinued until 08/06/25, one week after obtaining the results of the urinalysis. The record lacked any rationale for the delay. During an interview on 08/05/25 at 10:33 AM, the spouse of Resident #123 stated she had mentioned removing the urinary catheter to a nurse a couple of days earlier and was told the nurse would speak with the physician. The wife stated she thought it might be a good thing to get rid of the urinary catheter. During an interview on 08/07/25 at 9:50 AM, when asked the process for discontinuing the urinary drainage device for a resident who was admitted with one, Staff D, Unit Manager, stated they try to discontinue them timely depending upon the resident's history and orders. When asked the delay in discontinuing the urinary catheter for Resident #123, the Unit Manager stated she would have to look into it. During a subsequent interview on 08/07/25 at 12:54 PM, the Unit Manager referred to the progress note of Staff B, Nurse Practitioner, and urinalysis, both dated 07/29/25. When asked if that indicated a delay in services, the Unit Manager agreed. When asked if she spoke with the Nurse Practitioner about the delayed catheter removal, the Unit Manager stated she had, and the Nurse Practitioner had no comment.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, observation and interviews, the facility failed to follow their weight assessment policy for 1of 4 sampled residents, as evidenced by not reweighing Resident #68 after a significant weight gain.The findings included:Review of the facility policy, titled, Weight Assessment revised on 08/2023, documented, in part, .Weight assessment: 2. Weight Variance changes that are undesired or unplanned since the last weight assessment will be retaken as soon as practical for confirmation. If the weight is verified, nursing will communicate with the Dietician and/or the physician. Record review revealed Resident #68 was admitted to the facility on [DATE]. Review of quarterly assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 14 on a 0-15 scale, indicating mild cognitive impairment. Review of the care plan dated 07/15/24 revealed Resident #68 was at risk for alteration in nutrition / hydration related to his diagnosis of Depression, MS (multiple sclerosis) with a goal that the resident will not have any complications or alterations in nutrition. During an interview with Resident #68 on 08/04/25 at 10:49 AM, when asked how the food was, the resident stated, It's good. When asked if eating well, he stated, yes. When he was asked if he had lost weight, Resident #68 stated, No, I have gained weight, I weigh 180 pounds. Review of the current documented weight revealed Resident #68 weighed 180 pounds while sitting as of 07/25/25. The documented weight on 07/07/25 was 150.5 pounds while sitting, which indicated a 30-pound weight gain. The weights were reviewed and input in the resident's record by the Registered Dietitian (RD). Review of a progress note dated 07/25/25, written by the RD, indicated a weight clarification was needed due to the significant weight gain, according to the documented weight on 07/25/25. She stated she had spoken to Resident #68, who stated his usual weight was 175-180 pounds. The RD stated in her note that the resident will be reweighed weekly. Further review of the weights on 08/06/25 did not indicate that Resident #68 was reweighed. Further review of the past documented weights for Resident #68 revealed that on 10/08/24, he weighed 173.2 pounds while sitting and on 11/08/24, there was a documented weight of 159.2 pounds while sitting, which indicated a 14-pound (8.08%) weight loss. Following this significant weight loss, the facility failed to reweigh the resident for confirmation of an actual weight loss. Resident #68 was not reweighed until 12/30/24, at that time the documented weight was 172.4 pounds, which indicated a significant weight gain of 13.2 pounds. During an interview on 08/06/25 at 1:59 PM, when asked for an explanation of why Resident #117's weight was documented as 180 pounds on 07/25/25 and his weight was documented as 150.5 pounds on 07/07/25, the RD stated, Nursing staff enters the weights on a sheet of paper, and the RD reviews the weights prior to the weight being entered into the record. During an interview on 08/07/25 at 9:20 AM, when asked who was responsible for weighing the residents, the Director Of Nursing (DON) stated, the Certified Nursing Assistant (CNA) that is assigned to the resident is responsible for weighing the resident. When asked who inputs the weights into the resident record, the DON stated the dietitian inputs them into the system after the CNA records them in the book. When asked if she was aware of the 30-pound weight gain documented for Resident #68, after viewing the resident's weight, she stated, I don't understand why the resident was not reweighted right away.During an interview on 08/07/25 at 10:06 AM, when asked weren't there any weights taken on Resident #68, between 11/08/24 and 12/30/24, the RD said that she would look into it, and she would get back to me. She also stated she was not physically working in the facility during those times.Review of the weight book revealed the documented July 2025 weight for Resident #68 was 180 pounds, with no further weight document for the resident.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, policy review and professional standards, the facility failed to ensure respiratory services were adequately provided for 2 of 2 sampled residents as evidenced by the failure to provide oxygen as per physician order for Resident #91 and failure to assess Resident #105 during a nebulizer treatment. The findings included: 1. Review of the facility's Policy for Oxygen Administration, revised 12/2023, included instructions to review the physician's order for oxygen administration, and to adjust the oxygen delivery device so that the flow of oxygen administered met the resident's needs. Record review revealed Resident #91 was admitted to the facility on [DATE] with diagnoses that included Chronic Respiratory Failure, unspecified whether with Hypoxia or Hypercapnia, and Tracheostomy Status. The resident's documented Brief Interview for Mental Status (BIMS) score, per Minimum Data Set (MDS) assessment dated [DATE], was 8, indicating the resident had moderate cognitive impairment. Review of the MDS assessment showed that Resident #91 received oxygen during the 14-day lookback period. Review of Resident #91's care plan documented to administer oxygen as ordered. Record review documented Resident #91's physician order for oxygen dated 07/25/25, specified that the oxygen was to be administered to via trach collar at 3 liters (per minute). During an observation on 08/04/25, Resident #91 was observed lying in bed, with the oxygen concentrator tubing attached to the trach collar. The concentration of the oxygen that was delivered was set at approximately 5.8 liters per minute. Observations on 08/05/25 at 9:48 AM, 08/05/25 at 11:22 AM, and 08/06/25 at 8:25 AM revealed that the oxygen was delivered at approximately 5.8 liters per minute. Photographic Evidence Obtained. During an interview with Staff A, Registered Nurse (RN), on 08/06/25 at 8:35 AM, Staff A was asked how many liters of oxygen per minute were specified in Resident #91's physician order for oxygen administration. Staff A replied, 3 liters. Staff A went to Resident #91's room, viewed the oxygen concentrator, and stated the oxygen was set on 6 liters per minute. According to the doctor's order for oxygen, the oxygen concentrator should have been set on 3 liters per minute. 2. Review of the policy for Nebulizer revised 12/2023 documented, in part, to report information in accordance with facility policy and professional standards of practice. The facility managers were asked to provide the professional standards followed by the nursing staff. The facility provided a three-page document, titled, Nebulizer, that described what a nebulizer was and how to administer the medication. This process documented, in part, 9. Approximately five minutes after treatment begins (or sooner if clinical judgment indicates) obtain the resident's pulse. A medication pass observation with Staff D, Licensed Practical Nurse (LPN)/Unit Manager, was made on 08/06/25 beginning at 12:02 PM for Resident #105. The nurse obtained the aerosol medication, ipratropium bromide 0.2 MG (milligrams)/ML (milliliter), to administer to Resident #105. Lunch was (continued on next page)		

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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)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	served at this time, so the nebulizer was not administered. At 1:08 PM, Resident #105 had finished lunch, so Staff D obtained the nebulizer medication to administer to the resident. The LPN checked the resident's pulse and oxygen saturation. The nebulizer treatment was completed at 1:27 PM and Staff D obtained the pulse and oxygen saturation level again for Resident #105. During an interview on 08/07/25 at 12:54 PM, when asked about an assessment during a nebulizer treatment, Staff D, LPN and Unit Manager, was unaware of the need to assess the resident's pulse during a nebulizer treatment.		

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate Minimum Data Set (MDS) assessments for 2 of 27 sampled residents, as evidenced by inaccurate medication documentation for Resident #2 and inaccurate fall documentation for Resident #57. The findings included: 1. Review of the record revealed Resident #2 was admitted to the facility on [DATE]. Review of the current Minimum Data Set (MDS) assessment dated [DATE] documented the resident was being administered medications to include a hypoglycemic medication, which was used for diabetes or high blood sugar levels. Review of the corresponding Medication Administration Record (MAR) for the seven-day look-back period of 07/09/25 through 07/15/25 lacked any documented administration of a hypoglycemic medication. During a side-by-side record review and interview on 08/07/25 at 11:54 AM, Staff C, MDS Coordinator, agreed with the inaccuracy. 2. Review of the record revealed Resident #57 was admitted to the facility on [DATE]. Review of the MDS assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact. This same MDS assessment documented the resident had had no falls since admission or last entry, reentry, or prior assessment, whichever was more recent. The most recent event for Resident #57 was the previous assessment of 04/05/25. During an interview on 08/05/25 at 9:29 AM, when asked if she had had any falls while at the facility, Resident #57 stated she had had multiple falls here. Further review of the record revealed two falls between the assessment dates of 04/05/25 and 05/08/25 as follows: a) On 05/01/25, Resident #57 was observed lying on the floor. b) On 04/18/25, Resident #57 stated she fell in her room while walking to get to her wheelchair and that she got herself up off the floor. During a side-by-side record review and interview on 08/07/25 at 11:58 AM, Staff C, MDS Coordinator, agreed with the inaccuracy.		