STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235565	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westgate Nursing & Rehabilitation Community	1500 North Lowell Street Ironwood, MI 49938

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to Intake MI00152867. Based on interview, and record review, the facility failed to ensure licensed nursing staff maintained complete and accurate progress notes based on acceptable standards of practice for 1 Resident (R1) of 4 residents reviewed for complete medical records. This deficient practice resulted in lack of documentation in the medical record of the provision of wound care without a physician order, timely wound identification and documentation, and failure to provide notification and documentation of such to the physician and responsible party upon initial discovery of the R1's pressure injury wound. All times noted are Eastern Daylight Savings Time (ESDT) unless otherwise noted. Findings include: A review of intake information MI00152867, received 5/7/25 at 11:29 a.m., which alleged, in part: Complainant states that [Assistant Director of Nursing (ADON) A] and [the Director of Nursing (DON)] have directed staff not to open any more skin events because they do not want this information reported to the [State Agency] . staff put a patch on the wound (pressure injury on left iliac crest) but it is unknown if they are doing anything else to treat it (pressure injury) . family is not aware that she has this wound . Review of R1's Face Sheet, retrieved by the facility on 6/10/25 at 9:55 a.m., revealed R1 was initially admitted to the facility on [DATE] with diagnoses that included the following, in part: dementia, pressure ulcer of unspecified part of back, unstageable and abnormal posture (contractures). R1 had a Power of Attorney for Health Care and was unable to make independent medical decisions. Review of R1's Care Plans revealed a care plan problem initiated 5/15/2025, which read as: Resident has a [NAME] Terminal ulcer to lower left back/iliac crest. All interventions were initiated on 5/15/25, with the last review of the care plan performed on 6/6/25 at 21:16 [9:16 p.m. Central Standard Time (CST)]. R1 also have a Pressure Ulcer/Injury care plan initiated on 4/4/23 following initial admission. Interventions included the following, in part: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/20/25 - Areas of Skin Impairment, describe below . continues with dressing to hip area as scheduled. During an interview on 6/10/25 at 1:53 p.m., when asked if a pressure injury had been identified and treated prior to 5/15/25, when the wound was first documented, Confidential Nurse N stated, The ADON (ADON A) told me not to chart it . I questioned it (lack of documentation on the wound and wound treatment without a physician order) - if something (a skin event) was going to be opened up on it . The ADON just told us what to put on it (the wound) and we were told not to document it. Confidential Nurse N tearfully continued and said she had seen the wound when it first developed, and it was small. Nurse N positioned her thumb and index finger into a small circle showing the size of the wound upon initial identification to be approximately the size of a nickel. Nurse N said she was instructed to use wound cleanser, apply Aqua (something), which killed all the bad organisms in the slough away, and apply a border foam dressing to the wound. Nurse N said slough was present in the wound prior to May 15th, when ADON A opened up the skin event. Nurse N stated, I questioned [the DON] as well, because I wasn't comfortable (with no documentation of wound assessment or wound treatment of R1's PI) . I probably treated (R1's PI for a month with no physician order and no documentation of the wound . I complained constantly about the lack of charting and no physician order. During an interview on 6/10/25 at 2:10 p.m., Confidential Nurse O confirmed R1 had developed a pressure injury prior to being documented in the medical record on 5/15/25. Nurse O, with tears in her eyes, stated, It could have been the end of April 2025, or the first week of May that I saw the wound . When we seen (sic) it there was slough on it. It was not intact. It was small, on [R1's] left hip. I didn't document or open any skin event because I was told the family is so particular about her care. Even though R1 is declining they (family) want us to go above and beyond . Both of them (ADON A and DON) told me not to document the care because there was no physician order. We all didn't want to do it (omit documentation and family and physician notification of the wound) and were voicing our opinions, and they said no . We were told - we did not ask - to not document in progress notes and we were told to not open up a skin event. Nurse O said R1's left iliac crest wound was treated with Aquacel and a border foam dressing. Nurse O acknowledged she had seen R1's PI wound prior to 5/15/25, treated the wound per ADON A's direction prior to 5/15/25, and failed to document anything about the wound in the medical record because she was told not to do so. During an interview on 6/10/25 at 2:55 p.m., when asked about R1 having a PI prior to the initial documentation of the wound on 5/15/25, Confidential Nurse P stated, I had to do some digging and found out they had not updated the doctor or received a physician order (for R1's left iliac crest PI). There was nothing in the physician orders for me to know how to change the dressing. They (Nurse N and Nurse O) told me what they had been doing for dressing the wound . I asked if the family knew, and they said family was not aware . I told Nurse N, 'How does it look when you say there is nothing wrong (on the weekly skin reports) and then you have a Stage IV pressure injury when you are saying there isn't one.' I knew right away this was very wrong. They (Nurse N and Nurse O) were very afraid. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/11/25 at 7:30 a.m., the DON was asked about instructing staff to not document R1's PI wound in the Residents progress notes, failure to open up a skin event, and the failure to notify the physician and family of the presence of a new pressure injury for R1 that was found approximately a month prior to the 5/15/25 documentation of the new wound. The DON acknowledged LPN (Licensed Practical Nurse) C had asked her about it (documentation for R1's wound). The DON stated, I didn't realize it was such a huge thing, because she was the only one who came and asked me about it. I don't remember what she came and asked me . She did not tell me she had already talked to [ADON A]. I didn't go to [ADON A] either. I asked LPN C to go to [ADON A]. During an interview on 6/11/25 at 8:53 a.m., ADON A was asked about the lack of documentation of the initial discovery of R1's left iliac crest pressure injury. ADON A denied that any staff informed her of R1's PI and denied she had ever instructed nursing staff not to open a skin event, not to inform the physician and/or family of the wound, and to perform wound treatments without a physician order. When asked when a skin event is routinely opened, ADON A stated, Immediately. When asked when family should be notified of a change in condition, such as a new pressure injury, ADON A stated, Immediately, or as soon as something is found. The physician is notified the same day. I did call the physician immediately (on 5/15/25). When asked for documentation of that telephone notification, ADON A reviewed the medication record and said there was no documentation of a call to the physician on 5/15/25. During an interview on 6/11/25 at 10:15 a.m., with the Nursing Home Administrator (NHA), Corporate Consultant L, and the DON concerns related to the absence of documentation in progress notes, skin events, notification to the POA and PCP, and wound treatments performed without a physician order or documentation in the medical record were discussed. The DON acknowledged she did not go and make inquiry to the ADON regarding the issue with the earlier discovery of a wound on R1 in late April 2025, and therefore did not know what the outcome of the event was. Review of the Pressure Injury Prevention and Care policy, reviewed 1/2025, revealed the following, in part: . ^. Pressure injuries will be assessed and documented upon admission, readmission, upon discovery, and weekly thereafter. Assessment may include the size, location, category/stage, odor (if any), drainage (if any), peri-wound condition, wound edges, undermining, tunneling, exudate, pain, and current treatment order. 7. Physicians and responsible parties will be notified of pressure injury upon identification and with change in status of pressure injury. 8. Physician/provider will be notified . for further evaluation and recommendations regarding treatment and interventions. 9. Potential/suggested procedure with pressure injury identification: A. Notify the physician/provider and the resident's responsible party. B. Initiated treatment in accordance with facility protocols, standing orders, or physician orders. (continued on next page)

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