| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0582<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.<br><br>49735<br><br>Based on interview and record review, the facility failed to provide a complete Notice of Medicare Non-Coverage (NOMNC) and the Advanced Beneficiary Notice of Non-Coverage (SNF ABN) for two of four residents reviewed for Beneficiary Notice, resulting in resident and/or a resident representative not being informed of the right to appeal and the potential for undue emotional and financial hardships: Findings include:<br><br>A SNF (Skilled Nursing Facility) Beneficiary Notification Review form was provided to the facility for Residents R209, R210, R211, and R28 to be filled out by facility staff and returned for beneficiary notification review.<br><br>During an interview on 9/10/24 at 1:30 p.m., the Nursing Home Administrator (NHA) stated there was a problem with the form and asked this surveyor to meet with Corporate-Area Director of Utilization B and Minimum Data Set (MDS)/Registered Nurse (RN) C.<br><br>During an interview on 9/10/24 at 1:33 p.m., Corporate-Area Director of Utilization B and MDS/RN C revealed the facility had not completed the necessary NOMNC/ABN forms for the residents selected and requested Past Non-Compliance (PNC). Corporate-Area Director of Utilization B indicated noncompliance was found during internal audits of Beneficiary Notification Review. Corporate-Area Director of Utilization B educated MDS/RN C regarding completion of the form and the facility had conducted weekly audits since 8/13/24. The facility PNC form revealed the alleged compliance was 8/20/24.<br><br>Review of facility PNC documentation revealed that MDS/RN B was educated, weekly audits had been conducted, and no additional residents were affected.<br><br>During an interview on 9/11/24 at 1:20 p.m., the NHA stated, the identified PNC and audits would be brought to the Quality Assurance Performance Improvement (QAPI) committee during their next meeting in September of 2024 for resolution.<br><br>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included . education provided to MDS/RN C regarding NOMNC and ABN forms and audits were completed weekly since PNC was identified. This facility was able to demonstrate monitoring of the correction action and maintained compliance. |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123<br><br>Based on observation, interview and record review, the facility failed to implement measures to prevent additional pressure wound and/or prevent the development and worsening of pressure injuries for two Residents (R108 & R7) of five reviewed, resulting in harm for R108 with the development of a stage III pressure wound which worsened, required hospitalization , antibiotics, and wound debridement.<br><br>Findings Include:<br><br>(All times are recorded in Eastern Daylight Time.)<br><br>This citation is related to intake #MI00145848.<br><br>Resident 108 (R108)<br><br>Reivew of the complaint intake information from the State Agency, dated 7/23/24, read in part, .They stated he (R108) was doing fine .While driving up to see him on 4/19/24, [Licensed Practical Nurse] (LPN) D] called and said that dad wasn't doing well .She also told us that he has (sic) a pressure wound and she thought it was a Kennedy ulcer, which meant death was imminent within a few days to weeks. When we got there, (LPN D) met us at the door and said that 'we could move him to comfort care so he's comfortable'. I advised that we would be doing everything we can to get him better and rehabilitated .I scheduled a medical transport from [facility name] to (out of state facility) . Between the time I left on 4/27/24 and when he arrived in the out of state facility on 5/13/24, the wound grew in depth, and became extremely infected. It appears they [skilled nursing facility] did nothing to the wound after I left. A wound care Registered Nurse (RN) from (out of state facility) came to assess his pressure wound on 5/15/24 and she immediately called the ambulance because the wound was so badly infected, and she was afraid he was septic. In the emergency department (ED) out of state, they started intravenous (IV) antibiotics immediately. He was admitted and stayed in the out of state hospital until 6/10/24 . R108 was hospitalized for 28 days because of the severity of the infected pressure wound.<br><br>A Kennedy ulcer, also known as Kennedy terminal ulcer, is a specific type of pressure ulcer that manifests in terminally ill patients. A Kennedy ulcer is a distinct type of pressure ulcer that primarily affects individuals in the terminal stages of illness or nearing the end of life. It is characterized by its sudden onset and rapid progression, often appearing as a sharply defined, irregularly shaped lesion with a dark maroon or purple hue. Kennedy ulcers typically develop on the sacral or coccygeal area but can also occur on other pressure points, such as the heels, hips, or elbows. Kennedy ulcers are painful, non-blanchable lesions with surrounding tissue exhibiting signs of impending necrosis. Unlike traditional pressure ulcers, Kennedy ulcers may not exhibit the typical signs of tissue breakdown, such as erythema (redness) or inflammation. Instead, they often appear deep, crater-like wounds with minimal surrounding tissue trauma.<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 |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 9/5/24 at 4:54 PM, an interview was conducted with the complainant. The complainant stated, On three different occasions the wound care nurse told me that he (R108) had a Kennedy ulcer. I did not know any different and so I just did not think it was that bad and I thought the wound care nurse and the practitioner were providing the correct treatment and knew what they were doing. When we got to the hospital out of state the pressure wound was open (worse in depth visible with flesh, size, and odorous). I know that even with the wound he was not on a turn schedule at the facility prior to transfer. When we went to visit him in state name, they kept him up in his wheelchair for extensive periods of time and no one came in and turned him. We would visit for hours and hours at a time only briefly leaving to get something to eat. The medical transport van had two emergency medical technicians and a RN in the back riding with him and ensured he was being turned and repositioned every one to two hours and they stopped to get dad something to eat. The complainant stated, After my dad arrived in out of state facility I went to see him, and he said, 'Is that me that smells?' 'Is that my a**?' I replied, 'Yes dad. That is your a** that stinks.'<br><br>On 9/5/24 at 5:47 PM, Complainant I emailed photos of R108's pressure wound including one photo dated 5/8/24, which was taken while R108 was under the care of the facility.<br><br>A request was made to an out of state hospital for R108's medical records on 9/6/24 via fax.<br><br>On 9/6/24 at 1:11 PM, an interview was conducted with Family Member (FM) H, who stated, I can picture it just like it happened. On 5/8/24 I went to visit my dad and LPN D used their phone to take a picture of my dad's pressure wound. FM H stated, I had no idea it looked that bad. It got progressively worse. I could put my whole fist inside the wound he had. It was so bad. I swear on a stack of Bible's that the doctor was never there at the facility. They did not turn and reposition him and he was up in his chair 60% of the time. I went to see him three or four times while I was in the area. He was not on any antibiotics for the wound. I was not happy at all with what went on at the facility. They were shooting from the hip providing care for dad. We had a meeting with the nurse, physical therapist, and others to develop a treatment plan and the very next day they had it screwed up because they were not turning and repositioning him or changing the gauze on the dressing for the wound. They were making a plan because we had complained they were not doing their job turning and repositioning, so he was not on his right side. They called the wound a Kennedy ulcer. The dressing was a couple piece of gauze with some tape. On 5/8/24 they were putting A & D ointment on it. The wound care Nurse Practitioner (NP) spent ten minutes with him and never asked my dad a thing. He was not eating, was losing weight, and was losing his strength. My dad told me that the wound hurt, and he has a high pain tolerance. They just could not get their act together. I am so glad we had him transported elsewhere and now he is doing much better after receiving the treatment he should have gotten at the facility.<br><br>Review of R108's Admission Record, revealed an original admission to the facility on [DATE], with medical diagnoses including polymyalgia rheumatica (inflammatory disorder causing muscle pain and stiffness around the shoulders and hips), benign prostatic hyperplasia (age-associated prostate gland enlargement), hyperlipidemia (elevated blood cholesterol), and hypertension (elevated blood pressure). R108's admission Minimum Data Set (MDS) assessment, dated 4/15/24, revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating R108 had moderately impaired cognition.<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 |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of an Admission Skin Assessment, dated 4/10/24, revealed areas of skin impairment described as follows: right lateral inside toe scab, right side coccyx red area, left lower side back (lacked description), left hand (lacked description), left lateral outer arm near elbow bruise, right top of arm scab, and right shin old scar. No open areas of skin were documented in the initial skin assessment on admission.<br><br>Review of the Braden scale for prediction of pressure wound risk, dated 4/10/24, revealed a score of 16 which indicated R108 was a high risk for developing pressure wounds.<br><br>Review of a progress note, dated 4/11/24, read in part, Resd (resident) is being monitored for falls and weakness .Skin id (sic) dry and intact .Resd is Ax2 (assistance of two staff) with walker and Ax1 (assistance of one staff) for ADLs (activities of daily living) .<br><br>An MDS assessment, dated 4/15/24, section E0800, read in part, .Did the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being? .Behavior not exhibited .section M Skin Conditions, revealed R108 was at risk for developing pressure ulcers and had no unhealed pressure ulcers .<br><br>Review of a progress note, dated 4/18/24, read in part, Resd (resident) DTI (deep tissue injury)/blister to coccyx has opened. Red beefy tissue showing at wound bed, skin still partially attached. Will pas (sic) along to wound nurse for assessment . No mention of blister prior to this progress note.<br><br>Review of R108's skin integrity event incident report, dated 4/19/24, revealed R108 developed an in house acquired pressure injury on their buttocks that measured 10 (length) cm (centimeters) x 8 (width) cm x 0.4 (depth) cm.<br><br>Review of R108's Wound Management Detail report, dated 4/19/24 through 5/10/24 revealed the following:<br><br>a.) 4/19/24 - Wound type: Unspecified Ulcer, wound location: Right buttocks/coccyx, date identified: 4/19/24 at 12:30 PM, date created: 4/19/24 at 8:42 PM, present on admission: No, measured 6.0 cm, L (length) x 4.0 cm, W (width) x 0.3 cm, D (depth) cm. Wound comments: Res was found to have a blister-like area that opened on 4/18/24 with beefy red tissue showing to (sic) the wound bed. When doing skin assessments today, res presents with an unstageable wound that is likely a Kennedy ulcer to the right glut/coccyx area that is surrounded by a DTI (deep tissue injury) .DTI surrounding is dark maroon/red/purple and extends 5 cm.<br><br>b.) 4/26/24 - Wound comments: Res with an unstageable ulcer to the right glut/coccyx area that is surrounded by DTI. Necrotic tissue to entire wound measuring 5 cm x 3.7 cm with irregular edges and an area of slough to lateral side measuring 5 cm x 0.1 cm. DTI surrounding is dark maroon/red/purple and extends 4.7 cm from necrotic tissue in an irregular shaped circle pattern. Treatment changed. Light serosanguinous drainage noted.<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 |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | c.) 5/3/24 - Wound comments: Res with an unstageable ulcer to the right glut/coccyx area that is surrounded by DTI. Necrotic tissue to entire wound measuring 5 cm x 3.5 cm x 0.1 cm with irregular edges and an area of slough to lateral side measuring 4 cm x 0.1 cm. DTI surrounding is dark maroon/red/purple and extends 4. 0 cm from necrotic tissue in an irregular shaped circle pattern. Light serosanguinous drainage noted.<br><br>d.) 5/10/24 - Wound comments: Res with an unstageable ulcer to the right glut/coccyx area. Wound measures 5 cm x 3.5 cm x 0.2 cm with slough and granulation tissue scattered throughout the wound. Necrotic tissue that is 3 cm x 3 cm x 0.1 cm with irregular edges that is in the middle of the wound. DTI surrounding is dark maroon/red/purple and extends 3.5 cm from necrotic tissue in an irregular shaped circle pattern .Res with no s/s (signs or symptoms) of infection to area with light serosanguinous drainage noted .<br><br>Observation of the photo of R108's pressure wound, dated 5/8/24, revealed a Stage III pressure wound to the right sacral region, round in shape, dressing pulled down away from the wound revealing a completely saturated dressing with serosanguineous drainage; red/yellow in color. No 1/4 inch packing was observed as physician ordered. There was one piece of folded 2 inches (in.) x 2 in. gauze lying on top of the center of the padded dressing entirely saturated with serous drainage; clear and bloody in color and some yellow purulent exudate. The surrounding peri area of the wound was reddened and swollen all the way around the wound extending out approximately two inches. The wound had some purulent appearing drainage, undermining, mucus, stringy tissue, a brown and yellow piece of tissue in the center that appeared to be hanging off underlying tissue below that had some granulation. The dressing appeared to be an adhesive island wound dressing (porous) approximately 4 in. x 5 in. and in the center a pad measuring 2 in. x 2.5 in In the photo the wound appears to be larger than the dressing. R108's wound showed signs of infection in the photo dated 5/8/24 as described above.<br><br>Review of R108's physician order, dated 4/23/24 through 4/26/24, revealed an order to apply A & D ointment to right buttocks wound four times a day and as needed to keep wound protected.<br><br>Review of a progress note for R108, dated 4/23/24, read in part, .Side to side positioning every two hours and air mattress overlay. Wound healing supplement per facility . R108's physician orders lacked any order for an air mattress or for to check for settings and functioning.<br><br>Review of R108's care plan, dated 4/24/24, read in part, Problem: Urinary incontinence .provide incontinence care after each incontinent episode. Use moisture barrier product to peri area .Problem: Resident is at risk for skin breakdown .report any signs of skin breakdown (sore, tender, red, or broken areas.) .Problem Start Date: 04/19/24. Category: Pressure ulcer/injury. Resident has a pressure ulcer, DTI, R (right) buttocks, suspected Kennedy ulcer .Assess the pressure ulcer for stage, size, presence of granulation tissue and epithelization, and condition of surrounding skin 7 days .apply dressings per MD (medical doctor) order .<br><br>Progress note for R108, dated 5/7/24, read in part, Weight/wound review: current weight 194.8 pounds, down 7% in last 30 days triggers for significant loss, oral intake has dropped off recently to 0-25%, had been fair 50-75% .Recommend increasing oral supplement to 120 cc (cubic centimeters/4 ounces) three times a day .<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 |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Recap of Stay, dated 5/13/24, revealed, R108 was transferred to another facility out of state to out of state. R108's pressure injury wound was not measured prior to his discharge. Skin condition note was described as: areas of skin impairment and described as declining unstageable pressure injury right glut (gluteal/buttocks).<br><br>The discharge MDS assessment, dated 5/13/24, section M skin conditions, revealed R108 had no unhealed pressure ulcers . From review of R108's complete medical record it appeared the discharged MDS, dated [DATE], was inaccurate related to the related to the Wound Management detail reports.<br><br>Review of progress note, dated 5/13/24, read in part, .He (R108) does continue with declining unstage (sic) pressure injury to right glut. Does have occasional c/o (complaint of) pain to same .,Prior to leaving an order was given for prn (as needed) tramadol (pain medication) .Resident happy about transfer .Res. discharged at 4:05 PM (central time zone).<br><br>An interview was conducted on 9/11/24 at 10:02 AM, with LPN D. When asked if she recalled R108 and replied, Yes, I remember him well unfortunately. He was a nice guy. LPN D was asked if R108 had any open areas on admission and replied, No, but he did have a few scabs, a couple of bruises, and a small, reddened area to his right side near his coccyx. LPN D stated, R108 was at risk for developing pressure wounds. LPN D was asked what the initial treatment was and replied, Side to side repositioning and barrier cream. LPN D was asked when R108's pressure wound first opened and replied, It first opened up on 4/18/24 and was described as red, beefy tissue underneath. LPN D stated, I opened up wound management for R108 and I had the DON look at the wound on 4/18/24 and we called it a Kennedy ulcer. LPN D was asked if R108's wound was opened why she classified it as an unspecified ulcer. LPN D stated, Because I am not always sure what they are, but then I detail them in the notes section. So, in the notes is where I reflect what they are classified as. LPN D was asked if she could explain what a Kennedy ulcer was and replied, A terminal ulcer that is dark in color, opens fast, and has irregular boarders. LPN D was asked when the physician first seen R108's pressure wound and replied, The nurse practitioner came in to see his wound on 4/30/24 for the first time. LPN D was asked if pictures are ever taken of wounds and replied, No. LPN D was shown the photo of R108's wound dated 5/8/24 and replied, I did not take that the daughter did with her phone. That is R108's wound and yes it has redness surrounding the peri area. LPN D was asked if R108's pressure wound had any drainage and if it was ever cultured and replied, Yes, it had drainage, but just a light drainage and no it was never cultured. LPN D was asked if she was wound care certified and replied, No. I consult with the wound care representative and the nurse practitioner.<br><br>An interview was conducted on 9/11/24 at 10:58 AM, with the DON and was asked if R108 had an air mattress and replied, Maintenance would know when it was implemented because they keep a log of when air mattresses are added to resident rooms. The DON was asked if she could run a report for R108's turning and repositioning and replied, We do not keep track of that because it is a standard of care. The DON was asked how she would classify a pressure wound that appeared to be red, beefy to the wound bed and replied, A stage three. Well, it depends on depth so possibly a stage two depending on depth. The DON was asked what a Kennedy ulcer was and replied, It is an ulcer people generally get near the end of life and it is generally unstageable.<br><br>An interview was conducted on 9/11/24 at 1:01 PM, with the DON who was asked if air mattresses needed a physician order and replied, Not necessarily. The DON was asked if there should be a system to check off that the air mattresses are working properly and replied, We may or may not put an order in to check off that an air mattress is working properly, but it should be on the care plan too.<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 |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 9/11/24 at 1:15 PM, an interview was conducted with RN E who was asked if an air mattress needed a physician order and replied, Yes. RN E was asked if there is a system to check off if the air mattress is working properly and replied, Yes, usually an order and also on the care plan.<br><br>On 9/11/24 at 1:20 PM, an interview was conducted with RN F who was asked if an air mattress needed a physician order and replied, Yes. RN F was asked if there is a system to check off if the air mattress is working properly and replied, Yes, I know another resident has it where I check it off that it is working and has the setting in an order.<br><br>Review of R108's out of state hospital admission documentation, dated 5/15/24 through 6/10/24, revealed the following:<br><br>a.) .admitted to ED 5/15/24 reason for visit buttocks wound. Diagnoses: Sacral wound and cellulitis. Presenting problem: Infected decubitus ulcer. EMS states that the wound is odorous .<br><br>b.) Decubitus wound culture obtained in ED, labs drawn, IV inserted, and two different antibiotics started via IV. [NAME] blood cell count was elevated at 13.8 indicating infection was present in (R108) .<br><br>c.) ED basic information: Patient reports noticing the wound becoming more sore and has a mal odor to it. Assessment and plan: Sacral wound - open wound of lower back and cellulitis .<br><br>d.) ED Physical Exam: Right sacral wound about 4 cm x 6 cm, undermining a little 1 cm circumferentially, some purulent appearing drainage and a necrotic area of the skin on a pedunculated stalk .<br><br>e.) Medical decision making: . here for concern of an infected sacral wound. Patient reports he has discomfort and pain at the area of the wound .<br><br>f.) Transferred to inpatient at (out of state hospital) for further treatment .<br><br>g.) Wound care consultation note: Sacral wound on admission, unstageable sacral pressure injury. Upon debridement, the wound is likely to be a stage IV given the current depth that is visible. Concern about the amount of odor, necrosis, and cellulitis. Have requested evaluation by general surgery .<br><br>h.) Surgical consult note dated 5/16/24 read in part, Stage III right buttock/sacral pressure injury. Wound has become increasingly painful and malodorous over the last month. Wound debrided at bedside .Large amount of necrotic slough tissue within the wound bed was debrided .Wound cultures so far reveal heavy gram-negative bacilli .<br><br>i.) Progress noted dated 5/18/24, read in part, .The following day surgery came back and performed a more extensive bedside debridement as well .<br><br>j.) Progress note dated 5/21/24, read in part, .Assessment/Plan .Stage 4 skin ulcer of sacral region .Team saw the patient and suggested a wound VAC (a treatment that uses suction to help wounds heal) and that was placed on the 20th (May 2024) .<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 |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | k.) Progress note dated 6/9/24, read in part, .Assessment/Plan: 1.) Stage 4 skin ulcer of sacral region. The patient has a wound VAC in place. Medically stable for discharge. Awaiting insurance authorization .2.) Cellulitis of sacral region. On oral amoxicillin and clavulanate (antibiotic) .<br><br>l.) R108 was discharge out of the hospital on 6/10/24 .Discharge Diagnosis: Stage 4 skin ulcer of sacral region .Recent wound care assessment last week: Infected stage IV sacral ulcer, status post bedside debridement on May 15 (2024), status post surgical debridement on May 17 (2024) .wound VAC started on May 24 (2024) .Per last wound care assessment last week: Significant (sic) improved (evidence of a pressure wound and not a Kennedy ulcer) .Wound care team will follow-up in clinic in 1 to 2 weeks .<br><br>Review of R108's photo of the right sacral pressure wound, dated 6/14/24, revealed no infection surrounding the wound, significant reduction in size, and granulation tissue in the wound bed that appeared healthy.<br><br>Resident 7 (R7)<br><br>A quarterly MDS assessment, dated 8/13/24, section E0800, read in part, .Did the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being .Behavior not exhibited . section M skin conditions, revealed R7 was at risk for developing pressure ulcers and had one unhealed pressure ulcer stage II .<br><br>On 9/9/24 at 3:10 PM, an observation was made of R7 in his room, lying in bed. R7 had an air mattress that was set at 250 and static (not alternating pressure). R7's heel protector for his left foot was not on and his heel was touching the bed.<br><br>On 9/10/24 at 8:30 AM, an observation was made of R7 lying in his bed, on his back, in his room. R7's air mattress was set at 250 and static. R7's heel protectors were both off and were in his wheelchair. R7's left heel was overlapping a pillow and resting on the bed and R7's right heel was also touching the bed off a pillow.<br><br>On 9/10/24 at 8:35 AM, an interview was conducted with the DON, who was asked if R7's air mattress was at the correct setting and if their heel boot protectors should be on and heels off the bed and replied, I would have to check the orders for the air mattress settings to verify and the boots should be on and that the heels are to be floated. After reviewing the orders for R7 the DON returned and replied, The air mattress settings are incorrect.<br><br>On 9/10/24 at 11:05 AM, an observation was made of R7 lying in his bed, on his back, in his room in the same position from the previous observation.<br><br>On 9/10/24 at 2:00 PM, an observation was made with LPN D of R7's skin on their buttocks and peri area. R7's coccyx wound was healed, and their peri area was reddened with excoriation surrounding their peri area. LPN D stated, R7 was readmitted from a short hospital stay with a stage II (pressure wound) on their coccyx area. This area is known to open from time to time.<br><br>Review of R7's physician order, dated 7/13/23, revealed an order for a pressure relief air mattress with setting 320.<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 |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of R7's physician order, dated 10/3/23, revealed an order to check air mattress placement and functioning every shift.<br><br>Review of R7's care plan, dated 1/2/21, read in part, Category: Pressure ulcer/injury. Resident is at risk for skin breakdown . is also dependent on staff for repositioning and incontinence care .Approach .Heel float boot while in bed and wheelchair .Float heels while in bed .low air loss alternating pressure relieving mattress setting at 320 .turn and reposition every 1-2 hours while in bed .<br><br>Review of policy titled, New or Worsening Pressure Wounds, dated 1/2024, read in part, .Standard of Care: A resident who enters the facility without pressure wounds does not develop pressure wounds unless the individual's clinical condition demonstrates that they were unavoidable and a resident having pressure wounds receives the necessary treatment and services to promote healing, prevent infection, and prevent occurrence of additional wounds and worsening of existing wounds . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49735<br><br>Based on observation, interview, and record review the facility failed to ensure weights were monitored and nutrition interventions implemented for one Resident #41 (R41) of four residents reviewed for weight loss. This deficient resulted in a significant weight loss for R41. Findings include: (All times are recorded in Eastern Daylight Time unless otherwise noted).<br><br>Resident #41 (R41)<br><br>Review of R41's Minimum Data Set (MDS) assessment, dated 6/5/24 revealed admission to the facility on [DATE] with active diagnoses which included: dementia, hypertension, fracture, and anemia. R41 scored a 4 of 15 on the Brief interview for Mental Status (BIMS) reflective of severe cognitive impairment.<br><br>During an observation of R41 on 9/9/24 at 2:52 p.m., R41's clothes appeared large and hung loosely on the Resident.<br><br>Review of the MDS assessment dated [DATE] revealed R41 weighed 95 pounds.<br><br>Review of monthly weights revealed R41 weighed 93.7 pounds on 6/1/24 and R41 weighed 86.4 pounds on 7/1/24. This was calculated to be a 7.79% weight loss in one month.<br><br>Review of R41's Electronic Medical Record (EMR) found no dietary progress notes completed by Certified Dietary Manager (CDM) A or Dietician regarding R41's weight loss.<br><br>Review of R41's care plan titled Nutritional Status revealed, approach start date of 6/13/23 house supplement 90ml (milliliters) three times a day (TID) and 9/15/23 may have tray table with all meals .goal no significant weight loss.<br><br>During an interview on 9/11/24 at 10:32 a.m., the Director of Nursing (DON) stated every resident is weighed monthly .if we identify them as an unplanned weight loss then re-weighs are done .if there is a 5% weight loss in 30 days then we would re-weigh a resident .the physician and dietician would be notified as soon as we identify a weight loss . the dietician would request an order to add supplements and then the doctor would give an order for supplements . we didn't have a dietician at the time of the weight loss for R41 . the Certified Dietary Manager (CDM) A would have more information.<br><br>During an interview on 9/11/24 at 10:46 a.m., the Certified Dietary Manager A reviewed R41's weights and stated, I see where I needed a reweigh but one was not done . I don't see a progress note by the Dietician regarding the weight loss . the physician didn't order anything different for (R41) .interventions for the Resident experiencing a weight loss would be added to the care plan by the Registered Nurse (RN) doing the MDS assessments or the Registered Dietician (RD) .there was no supplement added for (R41) and no interventions were added to R41's diet or added to the care plan.<br><br>No documentation could be provided by the facility showed dietician/physician was informed and/or involved with assessing and treating the weight loss. There was not evidence of additional nursing interventions once the weight loss was documented.<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 |
|---|---|---|---|
| | 235565 | A. Building<br>B. Wing | 09/11/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Westgate Nursing & Rehab Community | 1500 North Lowell Street<br>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 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility policy titled Weight and Height Records Policy last revised 8/23, read in part . The facility staff will obtain and monitor resident weights as follows .residents will have their weight obtained .at monthly intervals unless more frequent monitoring is needed as determined by . a weight loss or gain of 3 pounds for those residents who weigh less then 100 pounds will result in a re-weigh .weight orders will be placed in the Electronic Medical Record (EMR) if more frequent monitoring is needed .those residents that trigger for a significant weight loss of greater then 5% from the previous month will be placed on weekly weights .and appropriate interventions will be put into place .weekly weights will be monitored .<br><br>Review of the facility policy titled Residents at Nutritional Risk Policy last revised 8/23, read in part . the following criteria will be used to identify nutritionally at risk residents .weight loss .of 3 pounds if [Resident] is under 100 pounds .in one month . once a problem has been identified .the primary nurse should work with the Dietician . in identifying approaches to be used .<br><br>Review of the facility policy titled Nutritional Assessment last revised 8/23, read in part . analyze weight pattern .compare current weight to weight 30, 90, 180 days .assess general downward .trend in weight . identify nutritional risk factors .weight below 100 pounds, weight loss of 3 pounds a month if below 100 pounds .document nutrition related problems and approaches .identify problems, goals, and approaches . evaluate effectiveness of interventions. |