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	12/04/2025

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to prepare food in accordance with professional standards for food service safety resulting in the potential to spread food borne illness among all residents that consume food from the kitchen. Findings include:On 12/2/2025 at 2:15 PM, during a kitchen tour with the Certified Dietary Manager (CDM) F it was noted that the drain line from the three-compartment sink extends down into the bowl drain causing an improper air gap. This drain line and the receiving bowl drain were noted soiled with excess food debris. When asked, CDM F stated that all dirty kitchen utensils that do not go through the dish machine are washed, rinsed and sanitized in this three-compartment sink. At 2:17 PM on 12/2/2025 it was noted the drain line on the vegetable wash sink was also indirectly connected to the bowl drain below it. CDM F stated that this sink was used for washing the facilities' vegetables before food preparation. At this time, it was also noted that the drain line for the facility ice machine located beside the vegetable wash sink extended down into the same bowl drain below the vegetable wash sink.According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to securely store medications in two of two medication carts reviewed for medication storage. (All times are recorded in Eastern Standard Time unless otherwise indicated.) Findings include: On 12/3/25 at 6:20 AM, an unattended pill cup was left on the South medication cart with one chewable 81 milligrams (mg) tablet of Aspirin. Licensed Practical Nurse (LPN) D was asked about the medication after she returned to the cart after the observation and stated she made a mistake and should have locked it up or taken it with her when she went to get the doorbell alarm.On 12/3/25 at 7:00 AM, an observation was made of the South medication cart for medication storage, and the following was observed:a. Various debris of paper and medication powder in the second drawer.b. One loose oblong capsule identified as gabapentin 300 mg with marking (IP 102) and beige in color.c. One loose round tablet identified as torsemide 10 mg with marking (PA 916) and white in color. d. One loose oblong tablet identified as valsartan and sacubitril 26 mg / 24 mg with marking (71) and white in color.e. One loose round tablet identified as quetiapine fumarate 25 mg with marking (U 25) and peach in color. On 12/3/25 at 8:20 AM, an observation was made of the North medication cart for medication storage, and the following was observed:a. Various debris of paper and medication granules of polyethylene glycol (over the counter laxative) and spilled liquid potassium in the second drawer.b. One loose round tablet identified as acetaminophen 325 mg with marking (GC 101) and white in color.c. One loose capsule identified as tamsulosin hydrochloride 0.4 mg with marking (D 53) and green/orange in color.d. One loose capsule identified as gabapentin 100 mg with marking (IP 101) and white in color. e. Two loose oval shaped tablets identified as metoprolol succinate extended release 25 mg with marking (M scored 1) and white in color.f. One loose round tablet identified as rivaroxaban 10 mg with marking (Xa, triangle on top of 10) and red in color.g. One loose round tablet identified as furosemide 40 mg with marking (3170 and V) and white in color. h. One loose round tablet identified as quetiapine fumarate 25 mg with marking (U 25) and peach in color. i. One loose round tablet identified as sitagliptin 25 mg with marking (221) and pink in color. j. One loose oval tablet identified as levocetirizine dihydrochloride 5 mg with marking (SG and 1-36) and white in color.k. One loose oval tablet identified as norethindrone acetate 5 mg with marking (AN and 475) and white in color. l. One loose oval tablet identified as apixaban 5 mg with marking (894 and 5) and pink in color. On 12/3/25 at 8:30 AM, an interview was conducted with LPN P who stated that carts should have been cleaned last night because the night nurses knew we were having a survey.On 12/3/25 at 8:35 AM, an interview was conducted with the Director of Nursing (DON), who was asked about medication storage and replied, Medications are not to be left unattended, and carts are to be cleaned regularly. On 12/3/25 at 8:45 AM, an interview was conducted with the unit manager Registered Nurse (RN) E who stated, I asked the night shift nurses to clean both medication carts out two days ago and obviously they did not. RN E verified that there was no official check off sheet that indicated the task for cleaning medication carts was completed and that cleaning was done with a vacuum. An interview was conducted on 12/3/25 at 9:00 AM, with LPN P who was asked about cleaning medication carts and accounting for all the loose pills in North cart and replied, Some nurses pop the pills over the open drawer and that makes me wonder if the resident is actually getting the medication or it is getting lost when replacing it back into the cart from the back of the pill blister pack. Either way there should not be any loose pills and night shift should have cleaned it last night.Review of policy titled, Maintenance of Medication Storage Areas, dated 4/2020, read in part A. CART: 1. Clean inside and out, including crushing devices.3. No medications on top of cart unless cart is under direct supervision.

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	235565	A. Building B. Wing	12/04/2025

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to ensure a correct therapeutic diet was prescribed for two Residents (#26 & #51) of eight residents reviewed for nutritional concerns. This deficient practice resulted in the potential for unmet nutritional needs and associated health complications. Findings include:(All times are recorded in Eastern Standard Time unless otherwise indicated.)Resident #26 (R26)R26 was admitted to the facility 10/2/2025 with diagnoses including failure to thrive, diabetes mellitus (DM), hypertension, and chronic kidney disease. A review of R26's Electronic Medical Record (EMR) revealed the physician had ordered a diet on 10/2/25 of Regular texture, No salt added, No Sugar added, Regular fluids.On 12/03/2025 at 9:20 AM, the breakfast tray for R26 was observed and included a tray with a salt packet despite the card which included the restriction of No Added Salt. Resident #51 (R51)R51 was admitted to the facility 11/7/2025 with diagnoses including congestive heart failure (CHF), chronic kidney disease and diabetes mellitus. A review of R51's EMR revealed the physician had ordered a diet on 11/9/25 of Reg/Reg Thin liquids (consistent carb [carbohydrate] and 2 g [gram] sodium). The care plan for R51 included a focus of Problem Start Date: 11/10/2025 Category: Nutritional Status (R51) is at Nutritional/Hydration risk due to history of CHF and DM . Approaches include: Approach Start Date: 11/10/2025 Diet per doctors order.On 12/3/2025 at 9:15 AM, the breakfast tray for R51 included 2 packets of regular sugar, salt and pepper, and had a tray card indicating a diet of Regular, SS (Sugar Substitute) but no indication of the sodium restriction ordered by the physician.Several other tray cards included SS on the diet order and the Certified Nurse Aides (CNAs) passing trays were questioned on the meaning of the term SS. The three CNAs passing the trays (CNA H, CNA I, and CNA J) all could not explain the notation. The Certified Dietary Manager (CDM F) was on the unit and explained SS indicated Sugar Substitute should be served rather than regular sugar packets.During an interview on 12/03/2025 at 4:49 PM, CDM F stated the facility did not serve a consistent carb or a 2 gram sodium diet. CDM F explained they offered an SS diet and an NAS (no added salt) diet as the facility had a liberalized diet policy. CDM F said that R51's tray card should have been changed and stated, I am surprised that the nursing staff did not know what the term SS meant. The online diet manual did not include a definition of a 2 gram sodium diet (a diet in which salt is severely restricted).During an interview on 12/3/2025 at 4:45 PM, Licensed Practical Nurse (LPN L) was asked the meaning of SS on the diet tray card and replied it meant soft diet.During an interview on 12/3/2025 at 4:54 PM, CNA K was asked the meaning of SS on the diet tray card and replied it meant soft diet.During a telephone interview on 12/4/2025 at 2:45 PM, the Registered Dietitian (RD M) stated the 2 gram sodium diet was not a diet we provide. RD M agreed the facility should follow the physician's orders.

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	235565	A. Building B. Wing	12/04/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor and record the amount of tube feeding administered to one Resident (#45) of one resident reviewed for tube feeding management. (All times are recorded in Eastern Standard Time unless otherwise indicated.) Findings include: Resident #45 (R45) Review of R45's face sheet revealed an admission to the facility on 9/23/25 with diagnoses including malignant neoplasm of esophagus (cancer in the throat), protein-calorie malnutrition, dysphasia (difficulty swallowing), and failure to thrive. Review of R45's admission Minimum Data Set (MDS) assessment dated [DATE] revealed R45's brief interview for mental status (BIMS) assessment was indicative of moderate cognitive impairment. On 12/02/2025 at 4:06 PM, an interview was conducted with R45 in their room. R45 stated he has a history of cancer and has a tube feed (G-tube) for enteral (anything involving the gut) feedings and is scheduled for the evening for feedings. Review of R45's physician order, dated 12/1/25, read in part (brand name enteral feeding) 1.5 via pump: nighttime feeding at 150 ml (milliliters) x 10 hours. No recorded total amount of tube feeding was recorded in the electronic medical record to ensure R45 was tolerating or receiving the amount prescribed by the physician or dietitian.Review of R45's progress note, dated 11/10/25 read in part .returns to the facility today.has a new G-tube due to inability to consume adequate kcal(kilocalorie)/protein intakes since admit last month.has lost 8% since admit 5-6 weeks -ago, which is considered to be a significant change. Current weight 150.4#. Wt (weight) from initial admit on 9/23 was 163.4# (pounds). Expect weight gain, which is desired.Will monitor tolerance to increase of tube feeding.Will continue to monitor tolerance to tube feeding, weight, labs, etc.R45's care plan dated 11/12/25 disclosed a problem in part .is at risk of complications D/T (due to) use of feeding tube.goal.will have all nutritional and hydration needs met.approach.Record and monitor intake and output every shift.Review of R45's intake dated 11/10/25 through 12/3/25 had no shift to shift intake recorded. R45's weights were reviewed:admission Weight 9/23/25- 163.4 pounds Weight 11/17/25- 147.6 pounds Between 9/23/25 and 11/17/25 a -9.67 weight loss in two months and between 9/23/25 and 10/20/25 a weight loss of -7.22 pounds in one month was discovered during the review of weights in the EMR for R45.Review of R45's progress note, dated 11/26/25 read in part .Weight does continue to trend down, no new weight this week. Last weight 147.6#. If weight continues to trend down, will increase enteral nutrition. Will continue to monitor. On 12/3/25 at 2:20 PM, an interview was conducted with unit manager Registered Nurse (RN) E who was asked about recording the amount of total volume tube feed delivered and water with medication flushes and replied, I do not know I have never had to record an amount before. I just sign it out on the MAR (medication administration record) that it was given. RN E was asked what if the pump gets turned off or there is residual and replied, I guess I never thought of that. RN E agreed that the total tube feed volume should be recorded to ensure R45 was tolerating and receiving the correct amount.On 12/3/25 at 2:25 PM, an interview was conducted with Assistant Director of Nursing (ADON) Licensed Practical Nurse (LPN) C who was asked if there was any documentation to show the nurses were recording the total volume of tube feed administered and water during medication passes for R45 and replied, I do not see any documentation of total volume recorded for tube feedings or water. It should be recorded so we know how much fluid they are getting. On 12/3/25 at 3:40 PM, the Certified Dietary Manager (CDM) F was asked if the total volume of tube feeding administered to R45 should be recorded so the dietitian would be aware of how much they are actually receiving and replied, Yes, that will assist the dietitian with determining if they are tolerating the amount of tube feeding and if it needs to be increased related to weight loss or decreased related to weight gain.Review of policy titled, Tube Feeding dated 01/2025, read in part .Purpose.When a resident requires special feeding techniques as ordered by the physician, the nursing and dietary department are responsible for the adequate intake (continued on next page)

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	235565	A. Building B. Wing	12/04/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of nutritional support. Proficient management of tube feeders assures fewer complications and improved general health status.The dietitian's responsibilities include evaluation of tube feeding volume and strength, total fluid intake.to ensure adequate nutrition.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure implementation of enhanced barrier precautions (EBP) during high contact care activities was performed per standards of practice for one Resident (#6) of one resident reviewed for EBP.Findings include: All times recorded in Eastern Standard Time (EST), unless otherwise noted.Resident #6 (R6)Review of the Minimum Data Set (MDS) assessment, dated 10/17/2025, revealed R6 was admitted to the facility on [DATE] and had diagnoses including paraplegia (paralysis affecting lower half of body), heart failure and chronic obstructive pulmonary disease (COPD). Further review of the MDS assessment revealed R6 required substantial/maximal assistance from staff for bed mobility, lower body dressing and putting on/taking off footwear.An observation on 12/2/2025 at 2:50 p.m. revealed a sign attached to the entryway of R6's room indicating the use of Enhanced Barrier Precautions (EBP) during high contact care activities. The sign indicated staff were to wear gloves and a gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing.On 12/2/2025 at 2:54 p.m., R6 was observed lying in bed with the head of the bead at approximately 70 degrees and his left leg bent at the knee and folded underneath his extended right leg. Indwelling catheter tubing was observed leading from R6 to a dependent drainage bag hanging on the left lower frame of the bed. R6 reported he was waiting for staff to assist him in repositioning his legs as he was unable to move his lower body unassisted. There was a sign observed posted on the wall behind R6's bed indicating the use of EBP during high contact care activities. During the observation, Certified Nursing Assistant (CNA) B entered R6's room, performed hand hygiene and donned protective gloves. CNA B then unhooked the catheter bag from the bed frame and placed it on the bed next to the resident. CNA B proceeded to lean over R6's bed to reposition the Resident's lower body so both legs were extended. CNA B then leaned over the resident lying in bed to assist him with plugging a phone charger into the outlet on the opposite side of R6's bed. CNA B did not wear a protective gown during the observed care provision which required close contact with R6.On 12/3/2025 at 1:35 p.m., CNA B and CNA A were observed in R6's room providing incontinence care to the Resident. CNA A was observed cleansing R6's buttocks of fecal matter with gloved hands while CNA B stood on the opposite side of the bed to assist R6 with maintaining a side-lying position during care. CNA A's clothing was observed in direct contact with R6 and the bed linens. CNA A assisted R6 with changing his shirt and then assisted CNA B with transferring R6 to their wheelchair using a total mechanical lift. CNA A then removed the soiled linens from R6's bed. The sign alerting staff to use EBP during high-contact care activities remained posted behind R6's bed. Neither CNA B or CNA A wore protective gowns while providing assistance with incontinence care, changing clothing and linens, or for transfer for R6.During an interview immediately following the observation, CNA A and CNA B were queried regarding the use of EBP during care of R6. Both CNAs acknowledged there were signs posted both on the door entering the room and on the wall behind R6's bed. CNA A and CNA B acknowledged protective gowns should be worn while providing care to R6.Review of R5's comprehensive care plan revealed the following: Start Date: 3/31/2025. Enhanced Barrier Precautions. Resident requires enhanced barrier precautions related to: Urinary catheter, PI [pressure injury] to bilateral thighs .Review of R6's physician orders revealed the following: Start Date: 11/04/2025. End Date: Open ended. Enhanced Barrier Precautions (targeted gown and glove use) during high contact resident care activities, foley catheter, bilateral stage 2 PI [pressure injuries] to posterior thighs.Review of the facility policy titled, Enhanced Barrier Precautions, reviewed 1/2025, revealed the following: Enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gloves use during high contact resident care activities . An order of enhanced barrier precautions will be obtained for resident with any of the following . wounds . and/or indwelling medical devices (. urinary catheters .) .